Tumaini: Hope

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Abstract

This thesis explored the question “In what ways are nurses’ sense making and meaning making affected by culture and context on a medical mission in Kakamega, Kenya?” A qualitative inquiry took place during a nurse-led medical mission in Kakamega, Kenya. Eight nurses’ journals, including the researcher, were examined for themes around the cultural and contextual factors upon which nurses reflected. A subsequent focus group was conducted with 5 of these nurses following the mission to confirm and clarify the data and explore any new themes identified. Findings demonstrated that as nurses compared their lived experience in Canada to the conditions they were encountering in Kenya, they became increasingly aware of gaps in their understandings. As they attempted to bridge the gaps of their inexperience, coping emerged as a significant theme by which nurses dealt with these unique cultural and contextual circumstances. The results imply the need for a stringent recruitment and interview process when considering participants for a mission and the necessity of comprehensive premission education for nurses. Primarily, it is essential to provide emotional support for nurses during and following the mission. It can be inferred from the implications of this study how organizations must be diligent in preparing nurses for all aspects of the mission including the significance of a unified team process.

Acknowledgments

I wish to express my love for my children, Eric and Amy, who have been and always will be my sources of inspiration throughout my life. They are always there and always will be my reason for being me. To my new grandson, Troy, who has been a true blessing to me, beyond what words can describe. I hope one day he will read this and be inspired to help others in his lifetime. Thank you to my husband, John, who listened, though not often understanding the stressors I dealt with along this educational path.

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I thank all nurses, especially those who have been and are involved with Canadian Nurses for Africa, as we are the people who can make a difference in this world. I thank God that I was led to meeting these nurses and experiencing the missions that I will be involved with for the rest of my life.

Most of all I thank the Kenyan people, especially those residing in the Kakamega and Vihiga areas of Kenya. Thank you for allowing us to care for you, work with you, and nurse you. Without your acceptance of us, this mission would not be possible.

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CHAPTER ONE: INTRODUCTION

Medical missions are a unique experience for nurses and are often glamorized by the media. Some critics label them as "medical tourism" (Suchdev et al., 2007, p. 317) considering the alluring appeal given to them. I admit I blindly went into my first mission with an idealistic attitude of being a savior to people in need. There are ethical concerns (DeCamp, 2007; Tolchin, 2007) around missions providing value for the volunteers over and above meeting the community's needs, inadequate standards of health care provided, and lack of continuity of services and sustainability of interventions (Green, Green, Scandlyn, & Kestler, 2009; Martiniuk, Manouchehrian, Negin, & Zwi, 2012; Suchdev et al., 2007). Additionally, there are obstacles to delivering ethical and justifiable health care (Rytterström, Cedersund, & Arman, 2009; Sörlie, Jansson, & Norberg, 2003). On assessing a tool to evaluate the quality of short-term medical missions, Maki, Qualls, White, Kleefield, & Crone (2008) confirm the need for education, training, and support for volunteers to prepare the participants for the challenges encountered during these missions. Redmond, O'Dempsey, and Taithe (2011) concur on the necessity for accountability and standards when offering health care to other countries.

I have been involved with Canadian Nurses for Africa (CNFA) for 3 years in helping implement an annual volunteer medical mission to Kakamega, Kenya, providing medications, treatments, and health teaching to residents of the area in various clinic sites. The mission in which this research took place involved five clinical days for the 1 week mission and 11 clinical days for the 2 week participation. The 2 week mission allowed one day off between the two clinical weeks. Nurses could choose to participate

in 1or 2 weeks of the mission experience based on their availability considering the length of travel and their opportunity to take vacation time.

The length of travel to reach the destination is 16 hours of flying and 8 to 12 hours of road travel. Nurses are financially responsible for their flights, accommodation, food, and any expenses acquired through travel and preparation for the mission (immunizations).

Clinics are organized in different areas in Kakamega and surrounding area on a daily basis in order to reach as many residents as possible. Each individual attending the clinics is registered with his or her name and chief complaint, triaged for acuity level and baseline assessment, and then seen by a Kenyan Clinical Officer. Medications are dispensed by Canadian nurses and delivered to the Kenyan nurse who is responsible for communicating directions to the patient for their treatment and providing health teaching relevant to their care. In the midst of this, various nurses are also performing wound care, deworming, and providing sexual health education within and beside the clinic sites. We also attempt to give items donated from Canadian people such as baby blankets, stickers, colouring books, and stuffed animals, mainly during triage as this is when there is the most direct patient care.

Multiple cultural and contextual issues have a significant impact on nursing care which we are not exposed to in Canada. There are limitations in our resources and support which create hopelessness and frustration for nurses when exposed to the vast, endless needs of people. After two medical missions and critical reflection during my second one, I recognize how essential it is to explore the perspective of nurses within the cultural and contextual milieu of the mission.

Topic

It is apparent that there are numerous factors contributing to nurses' experience during the mission. However, nurses are not homogenous in their worldviews and perceptions. Thus it is valuable to explore the perceptions of various nurses' responses to the context of working in Kenya. The topic of this research is *the experience of nurses during a medical mission in Kakamega, Kenya as influenced by cultural and contextual factors*.

Statement of Problem

In her transcultural care theory, Leininger (1988) describes culture as a group with learnt beliefs, norms, and practices that guide thinking, decisions, and actions (p. 156). The nursing culture is made up of compassionate, caring individuals, many of whom are service minded, motivated by the external and internal rewards of nursing, empathic with patients and families, yet able to maintain objectivity to establish therapeutic relationships (Sand, 2003, p. 178). The most substantial aspect is how "care is the essence of nursing and the central, dominant, and unifying feature of nursing" (Burhans & Alligood, 2010; Leininger, 1988, p. 152; Rytterström et al., 2009).

Nurses who attend the mission pay for their own flights and accommodations and use valued vacation time to participate in such an endeavor. We organize and participate in fundraising events throughout the year prior to the mission to purchase medications for patients attending the clinics in Kenya. There are no financial rewards or incentives to participate in the missions. Caring becomes very evident in this group of individuals.

Manias and Street (2001) indicate that skilled nurses depend on past experiences for their present and future patient interactions. Our work is "confirmed by following

familiar customs and routines" (Sörlie et al., 2003, p. 288). We are used to the role of expert and care provider in nurse–client interactions.

On the other hand, inexperienced nurses may conform to the expectations learned in the "culture of nursing," since they cannot depend on past experiences or familiar routines (Kavanagh, 1993). Sörlie et al. (2003) concur with this, indicating less experienced nurses rely on their colleagues' knowledge and experience. Unfortunately these practices predominantly reflect European, middle-class, White standards (Kavanagh, 1993) learned through our training and regulated by our workplaces. Stockhausen (2006) agrees that new nurses rely on "textbook and context-free rules to guide performance" (p. 55).

For example, referring to childbirth practices, Finn (1994) confirms how these customs rely on the "Western biomedical model" (p. 25). She identified two contrasting types of caregiving: generic health care which is culturally learned and transmitted and professional nursing care which is formal and taught through educational institutions. Within the professional realm, "peer learning" (p. 27) was distinguished as the informal influence of other nurses, similar to what Kavanagh (1993) and Sörlie et al. (2003) describe for inexperienced nurses. From my experience, I would agree with these data, that all nurses are compelled to comply with Western standards, which are often reinforced by institutional norms, standards, and regulations (Spangler, 1991). The diversity this causes is evident in Kenya with the people's belief in supernatural cures for diseases versus acceptance of preventative health care, use of folk home remedies to treat medical conditions instead of evidence-based practice, obvious gender hierarchy in which

males are seen at the clinic before women and children, and value of religion in all expressions of daily life (Leininger, 2001b).

In addition, Rytterström et al. (2009) describe how, for nurses, caring is not only directed toward the physical well-being of the client or the disease process. The client must be viewed holistically (Sörlie et al., 2003) from all aspects that impact on them as individuals and communities. On assessing what quality care means to nurses, Burhans and Alligood (2010) interviewed 12 nurses who worked in hospitals providing direct patient care. Empathic and respectful interactions, advocacy, and the intent to deliver quality care were the themes described as the foundation for nursing care. These are especially relevant during the mission when nurses intend to provide the same care they do at home then realize the complex cultural and contextual factors impacting on this provision.

Because of our role expectations and norms of practice, an internal dissension occurs when nurses are not able to fulfill the caregiver responsibilities in the way we are used to. In fact, my own experience has shown many nurses, including me, become discouraged during the mission and have described difficulty coping even on their return to Canada.

Rationale

One of our Canadian nurses' primary concerns, justified by DeCamp (2007) and Green et al. (2009), was the fostering of dependence on free health care. Green et al. (2009) interviewed volunteers, including health care providers, for a short-term medical mission (STMM) and found results compatible with the concerns of our nurses during our medical missions. Indeed Green et al. even describe how people would wait for

groups to arrive to access the free health care instead of seeking out ways they could help themselves. Mayo (as cited in Dowden, 2009) compares Africa's reliance on foreign aid to a parental dependence: "Support for your family is unconditional and in families you do not expect to be paid back" (p. 86). In other words, there is an expectation that resources would be provided without any self-determination from those receiving the charity.

In our daily clinics in Kenya, we always exhaust our supply of medication, which concludes that day's treatment for people, only to experience the same situation the following day. We have discussed the inadequacy of our efforts endlessly as a group, being aware of the need for sustainable interventions and empowerment of the people. Freire (1996) sums this up precisely by suggesting that

> false charity constrains the fearful and subdued . . . to extend their trembling hands. True generosity lies in striving so that these hands . . . need be extended less and less in supplication, so that more and more they become human hands which work and, working, transform the world. (p. 27)

Canadian Nurses for Africa's goal is not only for sustainability of interventions but for self-determination of the people. Nurses, however, struggle with how to facilitate this empowerment considering the vast contextual factors impacting the health of Kenyan people.

Another issue identified by nurses, especially by me as I worked directly with women in small groups as well as adolescents within the schools to provide sexual health information with the purpose of HIV prevention, was the incongruous information I provided. This stems from my White, middle-class, Canadian nursing perspective in

which we reinforce the ABC prevention interventions of abstinence, be faithful, and condom use (Dworkin & Ehrhardt, 2007; Higgins, Hoffman, & Dworkin, 2010), assuming that everyone has choices in their relationships. Freire (1996) consistently describes how the "top down" (p. 75) approach to education fails, as it does not take into account the worldview of the people towards whom the teaching is directed. This method is not empowering to the individual as it indicates working *for*, not *with* people, which is a condescending attitude indicating a "we know best" patriarchal viewpoint (hooks, 2000a & b).

The ineffectiveness of this strategy became apparent with my assumption that people could not afford condoms so distributing them would influence their use of them. I learned we cannot assume that differences in health care practices are due only to poverty and insufficient resources but may be due to cultural beliefs. I did not realize that requesting condom use was "an option of either social or biological death" (Holden, as cited in Brijnath, 2007, p. 380) for women. In fact a woman asked me what she should do when her husband beats her for requesting that a condom be applied. During my second mission, I learned Kenyan women were not allowed to view their partners' penises, thus making it impossible to apply the condom. Farmer (as cited in Green et al., 2009) describes how we must not "conflate poverty with culture" (p. 11); thus I had to recognize that it was not lack of access to condoms that placed people at HIV risk, but cultural beliefs around the use of them.

Cultural beliefs, availability and appropriateness of resources, and contextual factors impede nurses' ability to perform their innate caregiver role with people in great need. Nurses experience an internal conflict when the images we hold of ourselves as

nurses do not match with the issues we encounter during the medical mission (Alterio, 2004). This may contribute to difficulty coping during a mission or discourage nurses from choosing to participate in this valuable experience. Because of this, some nurses have indicated their choice not to partake in future CNFA missions.

In considering a model for sustainable short-term medical missions, Suchdev et al. (2007) describe seven principles for medical groups including sustainability, addressing health needs from the community's perspective, education and supportive team work for the medical groups, and rigorous evaluations. All literature reviewed on planning and evaluating medical missions reinforces the need for a collaborative, supportive approach in which the medical team receives education about the community to which they are traveling, the medical problems they will encounter, and the interventions that are culturally specific, prior to the mission taking place (Brown, Brown, & Yocum, 2012; Kelley & Salmon, 2007; Maki et al., 2008; Martiniuk et al., 2012; Suchdev et al., 2007).

It becomes evident that there is a need for research to be conducted to explore the experience of nurses on a medical mission from their perspective. Hiemstra (2001) describes "the resulting outcomes from values clarification . . . finding meaning in what is being examined, and developing wholeness as a professional through critical judgments enhance not only the professional but also the profession" (pp. 24–25).

Research Purpose and Question

The purpose of this thesis is to *explore the experience of nurses on a medical mission including their perspective of cultural and contextual factors influencing professional practice during the mission.* The research question is *In what ways are*

nurses' sense making and meaning making affected by culture and context on a medical mission in Kakamega, Kenya?

Audience

Exploring the experiences of nurses during the mission will not only help Canadian Nurses for Africa plan and implement preparatory sessions for new volunteers for future missions but will identify the options for support needed during and after the mission. Factors identified by the nurses will also assist in determining culturally relevant resources and interventions to strengthen the relationships and provisions appropriate for the Kenyan people in the Kakamega area. However, the most substantial benefit will be nurses' personal and professional growth and self-awareness through the process of journaling and critical reflection.

Outline of Remainder of Document

The remainder of this thesis will substantiate the research purpose, question, and methodology for this study. Chapter Two will illuminate the issues pertinent to the country of Kenya and the district of Kakamega by revealing the researcher's past experiences and literature supporting this. Chapter Three will describe the methods for this research, acknowledging the limitations and ethical issues pertinent to this study. The research findings and meaning of these themes will be discussed in Chapter Four. The implications of the findings will be highlighted in Chapter Five. The transcultural and critical theoretical foundations of the research will become apparent throughout the remainder of this document.

CHAPTER TWO: LITERATURE REVIEW

This literature review will examine research and statistics specific to the country of Kenya and district of Kakamega. It will bring to the forefront issues relevant to the Kenyan people and the impact these issues have on their health, which is supported by my own experiences from the three missions with which I have been involved. The critical basis of this research becomes discernible through the issues of poverty, power, and oppression. The relevance of transcultural theory to the research purpose and question will also be illuminated here.

Kenya

The postcolonial period in Kenya has seen poverty steadily increasing with almost half of the population living on less than $1 per day (Dowden, 2009; Foundation for Sustainable Development, n.d.a). It is apparent that when a country is impoverished, resources distributed toward health and education are often the first to be eliminated. Also, although poverty alone does not cause poor health, it is a proxy for other stressors. Inadequate prioritization of health issues, diminishment of family values, lack of social support, and limited alternative relationships options contribute to the link between insufficient income and poor health outcomes (Forna et al., 2006).

Dowden (2009) describes how, from 1992, poverty and infant mortality rates increased rapidly while life expectancy fell. Healthy life expectancy of males is 47 and of females is 48 (World Health Organization [WHO], 2010). The leading cause of death is HIV, with one of eight girls in rural Kenya and almost one of five adults in urban areas are infected with HIV (Foundation for Sustainable Development, n.d.b).

Kakamega

Kakamega district is one of eight districts of the western province of Kenya, and Kakamega is the town where Canadian Nurses for Africa carry out their clinics. The HIV/AIDS prevalence in Kakamega is the highest in Kenya at 23.8%, and the most affected groups are females aged 15 to 19 and males aged 19 to 35. Over 50% of hospital admissions are due to HIV, but most often, people cannot afford health care, medications, and treatments for any illnesses (Kahuthu, Muchoki, & Nyaga, 2005).

The region's growth rate has dropped due to HIV, and its dependency ratio of 100:108 indicates that most of the population is comprised of dependents due to parent death from HIV and orphaned children. This dependency ratio and the fact that households are often run by females, often grandparents raising their grandchildren, contributes to 52% of the population living below the poverty line (Kahuthu et al., 2005).

As well as HIV, the most prevalent diseases are malaria, skin diseases, and diarrhea. All are preventable with proper resources such as clean water, latrines, and access to food and health care.

One can understand how it would be difficult to maintain employment or continue education considering the illnesses that are prevalent in this area. In fact, poverty and illness contribute to unsuccessful completion of education evident by the primary school dropout rate of 26% (Kahuthu et al., 2005). Adolescent girls often do not continue their education but instead marry an older male who can financially support the girl and her family (Parikh, 2007). Unfortunately, this also contributes to the higher rates of HIV infection in younger women.

Women are at higher risk for HIV infection due to the biology of their genital tract, but cultural beliefs and poverty are major factors also contributing to this high infection rate (Kahuthu et al., 2005). Both Kenyan nurses' accounts and literature demonstrate that most of their men are unfaithful (Logan, Cole, & Leukfeld, 2002; Parikh, 2007). Parikh states that husbands are twice as likely as wives to bring HIV into the marriage through extramarital sex. Contrary to the North American HIV risk of men who have sex with men (Remis, Swantee, & Liu, 2010), being in a permanent relationship places women at higher risk for HIV than those who are never married, and the risk increases the longer they are married (Parikh, 2007).

Considering the multiple health issues, one would hope for resources for treatment and prevention. Unfortunately there are insufficient health practitioners within Kakamega. The doctor:patient ratio is 1:14,246, and health facilities are inaccessible and short of supplies. The nearest health facilities are 10 kilometers in rural areas and 500 meters in urban areas (Kahuthu et al., 2005). Bikes or motorcycles are available for transportation, but most people cannot afford them so they must walk for kilometers to attend our clinics.

Poverty and Power

Considering the unrelenting poverty in Kenya, one can presume the powerlessness of the people as all their energy is directed toward meeting their most basic needs. Originally, when working with the Kenyan people, I assumed their poverty led to powerlessness and contributed to poor health. An initial literature review reinforced how power is based on the amount of resources that one person possesses compared to the other (Harvey & Bird, 2004; Pulerwitz, Gortmaker, & DeJong, 2000).

However, considering power from a critical theory perspective in that "those with less income or consumer goods are not always powerless" (Brookfield, 2005, p. 124), it can be contended that power is within each individual, but there are societal forces impinging on the individual's ability to liberate it.

Oppression

Poverty, inequality, and injustice are perpetuated through apparatuses of society that sustain oppression of the people (Brookfield, 2005; Collins, 1989). "Repressive state apparatuses" (Brookfield, 2005, p. 74), such as the law and politics, are used to enforce the obedience of the people. Violence is common from authorities, within workplaces, and against women (Kahuthu et al., 2005). Coercive forces were evident to nurses when our vehicles were stopped by police and allowed to pass only when payment was received. It seems to us that dishonest police are controlled by corrupt politicians and led by a largely deceitful government.

The Report on Kakamega (Kahuthu et al., 2005) acknowledges how the "misuse of power" (p. 14) and "lack of transparency" (p. 15) interfere with many attempted social and health programs and how officials are "feared by the residents" (p. 14), thus inhibiting them from seeking justice. Politicians are frequently self-interested and appointed because they will comply with the government. Dowden (2009) emphasizes that "the only distinction between Kenya's politicians was between those who were in and those who were out" (p. 434). Freire (1996) describes how leaders maintain their status by deceiving their communities and continuing the people's oppression.

Dowden (2009) portrays these corrupt rulers as "the Big Man [who] likes to demonstrate how far he is from the squalor that most fellow citizens live in" (p. 77). In

fact I noted that these politicians dressed in suits and jewelry, had cars and drivers, used cell phones and exhibited an air of authority, thus demonstrating their wealth compared to the masses they ruled. I became even more aware of their deception when they attended our clinic with their video cameras, proclaiming to all how they had organized this clinic so their people could have free medications. In actual fact, we pay for our flights, purchase medications from fundraising, and require "permission" from the leader of the area only to run the clinic. When questioning the leaders about the resources available to the people, they proclaim that education and medications are free. As evident by the data above, contextual factors prevent children from completing school, clinics are not accessible, doctors are insufficient in numbers, and there is a cost to register at clinics and hospitals. Freire (1996) describes this as the myth of the "free society" (p. 120) in which leaders "deposit" these lies to keep the people passive.

When questioned about the economy, one of the political leaders implied that agriculture as employment could be lucrative but the people did not want to farm. Again, this is another myth, since farming is done mainly by women who earn only a small portion of the income generated and do not actually own the land. Nearly 40% of households are run by these women (Foundation for Sustainable Development, n.d.b), therefore one can understand the "feminization of poverty" (Dworkin & Ehrhardt, 2007, p. 13; hooks, 2000a, p. 42) in that women are disproportionately affected by inadequate income.

Religion. The oppression of the people is maintained by "Ideological State Apparatuses" (Brookfield, 2005, p. 74) such as the church and school to reinforce principles which sustain oppression. Religion is a significant value to African people

(Eiser & Ellis, 2007). I witnessed the value of church and religion during my stay in Kenya by the joyful parading and singing on the way to church on Sundays, their joy amongst the poverty and illness.

Religious beliefs reinforced passiveness in the community, as individuals fatalistically transferred the responsibility of their oppression onto God because "it is the will of God and I must accept it" (Freire, 1996, p. 145). This indicates the resignation of the people to "accept as natural and in their own best interest an unjust social order" (Brookfield, 2005, p. 43). Political leaders stated that people would spend most of their time in churches instead of working. Our slowest clinic day was Sunday as the people spent half of the day in church. Often, when looking out at the crowds at the clinic, hopelessness was evident on their faces.

Although literature is not available from Kenya itself, Hatcher, Burley, and Lee-Ouga (2008) describe how, for Black African women, religion permeates every aspect of their lives. Thompkins (2004) also confirms that in an interview of Black women in which they were asked what helped them get through bad times, 75% of these women volunteered faith, God, and church as sources that helped propel them through the struggles they face. Similarly, in her research on pregnant African American women, Morgan (1996) found that, even with no religious affiliation, support came from their "relationship to God" (p. 6). hooks (2000a) concurs with this when describing Black women's religious experience, stating that "females have found in spiritual practice a place of solace and sanctuary" (p. 105).

Unfortunately, religious leaders emphasize the male-dominated hierarchy in which women must defer to male authority. Indeed, the values impressed upon by the

church are consistent with a traditional masculine role described by Bredstrom (2006) and Logan et al. (2002) which supports sexual promiscuity of men and views male sex drive as a biological force, not to be interrupted by condom use. Although Hatcher et al. (2008) researched the African church in the United States they acknowledge how these conservative beliefs permeate the Black church culture which has not progressed to addressing how these issues impact women's HIV risk.

The religious beliefs accepted by the Kenyan people sanction inequities between men and women which mainly effects women's health. The male-dominated hierarchy was very evident during our medical missions when men, especially church leaders, would walk directly to the front of the clinic line to be seen before the sick women and children who had been waiting for hours.

The outcome of this gender hierarchy is immense. One can understand why females are at higher risk for HIV. Many of the denominations forbid the use of contraceptives and validate the male-dominated role that sustains infidelity of men and subservience of women. Extramarital relationships are not to be questioned, and "secondary households" (Parikh, 2007, p. 1201) were common in men with wealth who identified themselves as highly Christian. Ironically, in sub-Saharan Africa, wealth and income increase HIV prevalence (Higgins et al., 2010), probably due to the fact that the men can afford numerous wives. In an effort to keep their men sexually satisfied and perhaps reduce infidelity, women would perform cultural practices such as vaginal drying to enhance sexual pleasure, which biologically increases their risk for HIV even more (Kun, 1998; Williams, Newman, Sakamoto, & Massaquoi, 2009).

I became especially sensitive to this issue during the mission in which this research took place as I was the only nurse providing sexual health education. One would consider condom use in marital couples unnecessary but, considering the infidelity, I could see no other options for HIV prevention. To compensate for the males' unwillingness to wear condoms, I encouraged female condom use, only to discover that some of the men's cultural beliefs were that women would capture the sperm and take it to the witch doctor to erode their virility (Watson & Stratford, 2008). An additional cultural practice contributing to married women's HIV risk is "wife inheritance," in which the widow is inherited by a male relative of the deceased husband, with the requirement for her to have sex with a man of "low social standing" to cleanse her of the dead husband's evil spirits (Foundation for Sustainable Development, n.d.b). This is not only degrading to the woman but substantially adds to her HIV risk. It is evident how cultural practices became hegemonic ideologies (Brookfield, 2005) endorsed by the church, which increases HIV risk for women.

It became apparent very early in the medical mission that the ABC (Dworkin & Ehrhardt, 2007; Higgins et al., 2010) HIV prevention methods I used in Canada were inadequate strategies to be utilized in Kenya. Abstinence is unrealistic in a marriage, and the "be faithful" strategy can increase risk as men become more cautious and attempt to hide infidelity more (Parikh, 2007), placing the risk of getting caught as more important than the risk of being infected with HIV. Having women insist on condom use was doomed to failure (Higgins et al., 2010; Quinn, 1993) and potentially dangerous for Kenyan women. Allgeier and Allgeier (as cited in Logan et al., 2002) describe this as the

"gatekeeper theory" (p. 867) in that women become responsible for setting limits on both their and their partners' behaviours.

Education. Repressive power (Brookfield, 2005) is also maintained by schools to teach a doctrine which continues oppression of the people. The main teaching style is rote education eliminating any facilitation for critical thinking, questioning, and discussion. Education in Kenya also seemed to enforce dominant ideology to program thought to comply with White European standards including language and curriculum.

In my work in the schools, it was shocking to view how the children would be forced to reply in English by raising their hands, standing up, and responding in awkward, stilted English, expected to use the proper terminology. Under no circumstances was there an opportunity for open discussion, and any questions I asked were met with a stare, the children searching my face for the answer I wanted. Freire (1996) describes this as the "banking concept" (p. 54) of education, which promotes passivity of the student in the authoritarian society that does not want to encourage individuals to challenge the status quo. This is in contrast with the critical theory approach in which "learning [is] tinged with criticality" (Brookfield, 2005, p. 249) to question the system. Brookfield also notes that society would have to permit this kind of learning, so one can see why this would not be encouraged in Kenya where compliance of the people was enforced.

Nursing education in Kakamega seemed similar, with memorization of facts and technical application of skills with none of the problem-solving or critical thinking skills that I was used to from my nursing education in a university in southern Ontario. Similar to the commodity exchange described by Brookfield (2005), Kenyan nurses described

how they would emphasize higher education for their children in order to exchange this for adequate income, basic sustenance, and, most hopefully, their only route to leaving their country. Indeed I had many nurses requesting me to sponsor them in Canada, which they saw as their only chance for success.

Transcultural Theory

It becomes evident the vast differences between Kenya and Canada with respect to social structure factors such as political, legal, economic and education issues, religious and cultural beliefs, and world views and life patterns (Finn, 1994). These differences have an effect on the provision of health care during the mission, especially when considering how care and caring are an essential quality for nurses to achieve a sense of meeting their clients' needs.

Madeline Leininger, a prominent nursing anthropologist, developed her transcultural theory in the 1950s to shift nurses from a traditional unicultural viewpoint to a multicultural conceptualization of nursing care. Leininger has since studied 52 cultures and noted the marked differences between Western and non-Western cultures (Leininger, 1988). Her vision was to prepare nurses to provide sensitive, compassionate care for people of diverse cultures (Leininger, 2001c). Her ethnonursing method (Mitchell & Cody, 1992) was designed with the "goal to discover new nursing knowledge as perceived or experienced by nurses and consumers of nursing and health services" (p. 174), which is compatible with the research purpose.

Finn (1994) used Leininger's theory to examine women's experiences and nursing care patterns and practices for European and American women during childbirth from the view of the women and nurses caring for them during the births. She confirmed that

there were "Euro-American cultural values related to childbirth" (p. 32) such as the need for couples to attend prenatal classes together. She also found significant results for professional practice which emphasized the adaptation of care so women could experience a beneficial and satisfactory delivery, such as expression of pain and requirements for pain relief.

Cortis (2000) used Leininger's theory as a conceptual framework to "discover the worldview, cultural values and life-ways of Pakistani immigrants" (p. 55). She confirmed the link between culture and caring, and results also described the indication of delivery of caring by nurses. For example, empathy, support, listening, and communication skills were identified as caring over the mechanistic and ritualistic qualities of modern nursing (pp. 58–59). These results are significant to me when comparing our roles in the clinics and deliberating how we can consider culturally congruent, sustainable, and empowering interventions.

Though providing significant results for professional practice, much of the research completed using Leininger's theory and ethnonursing method is from doctoral dissertations. Gates (1988) explored experiences of dying persons in hospital and hospice settings which identified suggestions for nursing practice within five different themes discovered from patients, staff, family, and volunteers. Macneil (1994) uncovered expressions of care for women providing AIDS care to family members in Baganda and found substantial information to provide culturally congruent nursing care to families afflicted with AIDS. Similarly, George (1998) discovered valuable knowledge for nurses to use when caring for chronically mentally ill patients living in the community. On a different note, Gelazis (1994) investigated humor as related to care and

well-being of Lithuanian Americans. One significant result was the influence of their ethnicity and cultural identity to maintaining their sense of health and well-being. Thus the use of Leininger's theory has demonstrated valuable results in terms of exploring the experiences of nurses and clients in various settings, including the effects on professional practice and provision of culturally congruent care.

Although she has not studied Kenyans living in Africa, Leininger (2001b) identified cultural care values and meanings for African Americans that are consistent with my experience in Kenya. For example, the significance of extended family, reliance on folk home remedies, meaning of religion and praise with song and worship, and value of technology such as cell phones and cars were identified as themes within her research. Morgan (1996) used Leininger's transcultural theory and ethnonursing method to discover the beliefs, practices, and values of pregnant African women living in America. Consistent with Leininger's results and my experience, Morgan identified the significance of spirituality in these women's lives and the belief in "generic or folk health care" (p. 9). Considering the cultural and contextual diversity between Canada and Kenya, it is apparent that Leininger's transcultural theory is an ideal theory to explore nurses' perspectives when providing care to Kenyan people.

Summary of Literature Review

This literature review demonstrates the impoverished state of Kenya, with the profound impact on the citizens' health and welfare. As Kenyan people attempt to achieve their most basic survival needs, one can understand how they are unable to escape from their overwhelming circumstances. Religion and education sustain their subjugation and this oppression serves to protect an apparently corrupt government. This

context contributes to a complex, multifaceted issue mainly affecting women and children's health.

Many of these contextual factors are upheld by cultural beliefs and values of the Kenyan people. When considering how to provide nursing care to the people within this cultural and contextual milieu, nurses must be able to practice by their professional standards while being respectful of the cultural aspects of their clients and their community. Most significant from this literature review is the evidence of the diversity between Kenya and Canada and the challenge to explore how nurses make sense of these differences through this research.

Chapter three will describe the methodology of this research. The research design, sample, and methods of data collection and analysis will be explained. Ethical considerations and limitations of the study will be acknowledged.

CHAPTER THREE: METHODOLOGY

The methodology for this thesis was a qualitative inquiry in that I relied on the views of my participants, collecting data from their own words, analyzing this text for themes related to the research question (Creswell, 2008). This research was conceptualized within Leininger's transcultural nursing theory (Leininger, 1988) using some components of her ethnonursing method. A critical theory paradigm was also considered as a basis for this thesis. Data collection was accomplished in two phases, first through journaling and second through a focus group.

Design

A qualitative inquiry was the most appropriate design for this study with the purpose of discovery and exploration (Mitchell & Cody, 1992). Leininger's transcultural theory linked culture and care into a meaningful relationship (Leininger, 1988) which was ideal to explore "care as a concept in nursing" (p. 154) considering the voluntary participation in this challenging experience. Her ethnonursing method focuses on "naturalistic, open discovery . . . to document, describe, explain, and interpret informants' worldviews, meanings, symbols, and life experiences" (Douglas et al., 2010, p. 378S), which was optimal to tease out embedded care and nursing knowledge with data from nurses' viewpoints.

Ethnonursing was utilized from a theoretical standpoint, with its purpose to "discover unknown or vaguely known complex nursing phenomena bearing on care" (Douglas et al., 2010, p. 378S). This was compatible with the research purpose, which considered the cultural and contextual factors influencing professional practice.

I had hoped that information gained using this design not only would extend the body of nursing knowledge (Leininger, 1988), but, most significantly and analogous with this thesis, was how Leininger identified that "without self-awareness, the nurse may experience culture shock and be unable to help clients" (p. 348). Cortis (2000) agrees that learning from another culture makes us more conscious of our own culture, and for some this can be an "unsettling experience" (p. 59). However, reflecting on how one's own cultural care values and expectations are different from another culture's, can help one to understand and reduce conflicts, frustration, and imposition practices (Leininger, 2001c), all of which were the issues leading to this research.

I recognized that although this study extends from the recognition of my experiences during the past missions, other nurses may not have similar discord or dissensions based on cultural and contextual issues encountered. Thus, I digressed from the process of the ethnonursing method in that I did not use the sunrise model in which findings are interpreted in light of cultural care preservation/maintenance, accommodation/negotiation, and repatterning/restructuring (Leininger, 1988; Morgan, 1996). I felt the use of a model would limit interpretations to only the cultural context and would not contribute to the "naturalistic, open discovery of nurses' worldviews and life experiences as they bear on nursing care" (Douglas et al., 2010, p. 378S). Leininger acknowledged that the sunrise model should not be used from a causal or linear perspective and suggested that alternative models may be better utilized for transcultural research. Tortumluoglu (2006) reviewed four models commonly used for transcultural nursing and agreed that while Leininger has provided the basic foundation for practice, her theory may be refined to apply to the particular research.

In addition, the ethnonursing process involves the use of key and general informants (Douglas et al., 2010; Leininger, 2001a; Morgan, 1996). Due to the nature of this study and the ethical issues surrounding it, I used only general informants as the sample which was the Canadian nurses. Key informants such as Kenyan people and nurses may have contributed to power over (Ponic, Reid, & Frisby, 2010) issues, since patients receive free treatment from CNFA and Kenyan nurses receive a stipend to work with us. Thus both may have responded more favorably to interviews or questions from me as a CNFA nurse and researcher which I sought to avoid.

Schram (2003) describes how it is essential to connect with a paradigm to guide a qualitative inquiry and the researcher's interpretations (Mitchell & Cody, 1992). It would have been negligent not to exercise a critical analysis considering the issues of oppression, gender inequality, and repressive power as identified in the literature review. A critical focus with its intent to bring about change through advocacy and activism (Schram, 2003), to free people from oppression, unmask power, and challenge ideologies (Brookfield, 2005) may be considered a long-term goal for CNFA as we always are considering empowerment of the people and sustainability of our interventions.

Therefore, the most appropriate paradigm for this research focus was the transcultural perspective combined with critical theory to consider issues within Kenya and also to encourage nurses to reflect upon their own norms of practice and how they are influenced by White middle-class hegemonic ideologies which may be incompatible with other cultures. Thus the critical and transcultural approach provided a "forum for consciousness-raising from which nurses can work together in an endeavour to understand and restructure their clinical practices" (Manias & Street, 2001, p. 235).

Lather (2003) identifies this as “catalytic validity” (p. 191) in which the research itself inspires action, change, and transformation, empowering the individuals participating.

Sample

All nurses attending the medical mission were invited to participate in the study. This sample was purposeful in that participants were intentionally selected as volunteers on the medical mission and homogenous in that all are nurses from Canada (Creswell, 2008). Eight of the 14 nurses volunteering for the mission signed the informed consent to participate, including me. Two of the participating nurses did a 1 week mission while the remainder did the full 2 weeks.

In order to maintain confidentiality, no identifiers were obtained on participants other than age, years of experience in nursing, and types of nursing experience. The median age of the participants was 49, with a range from 19 to 60 years of age, and the average number of years of nursing experience was 22. The nursing experience ranged from medicine, emergency, critical care, and some also had worked as educators, public health nurses, and in long term care.

In total, eight journals were analyzed for the initial data collection. Five of these nurses attended the focus group, which does not include me as I did not contribute to the data except to ask the questions or verify any comments.

Data Collection

Methods used for data collection were nurses’ journals followed by focus group interviews. These data collection methods were ideal tools for exploring personal reflections about nursing during the mission. Torsvik and Hedlund (2008) examined nursing practice and cultural encounters of nursing students, using a similar design and

data collection methods, and noted valuable results in terms of cultural competence, critical reflections, and self-awareness, all contributing to the practice of nursing.

Journaling

Journaling is a powerful tool connecting the personal and professional worlds (Walter, Davis, & Glass, 1999), which not only enhances personal and professional development but may also improve patient care (Clarke & Graham, 1996). Alterio (2004) simply describes journaling as "a way of making sense of complex experiences" (p. 321). Scott (2006) elaborates on journaling, describing how it is a way "the collective unconsciousness becomes more available to us" (p. 159).

Journaling not only increased my self-awareness (Cox, 2005; English, 2001; Neill, 2006) but was therapeutic in that it facilitated restoration and healing after intense, stressful, hectic clinic days. Indeed, Peterson and Jones (2001) describe how women's journals can be a "blend of reflection and catharsis" (p. 65). In this manner, journaling is an ideal tool considering the intensely threatening emotional experience (Mezirow, 2000, p. 6) that nurses experience with the complex cultural factors, oppression, inequality, and injustice to which we were exposed on this mission. Fonow and Cook (as cited in King, 1994), describe how, through reflecting on their own experiences, women can "truly understand gender asymmetry and the plight of marginalized people" (p. 20). This demonstrates how powerful a tool journaling can be for this specific experience.

Schön (as cited in Boud, 2001; Clarke & Graham, 1996) describes the differences of reflection *in action* and *on action*. *In action* is similar to the ethnonursing design that requires the researcher to be in the natural setting of the group being studied (Leininger, 2001a). For this research, the natural setting is the clinics in which we work. My focus

was on the "*emic* (local or insider's) views" (Leininger, 1988, p. 153), with concentration on the expressions, symbols, and patterns of the context of culture (Leininger, 2001a) and their effect on nurses.

Ong (2011) describes how experts in their fields of work use this type of reflection intuitively to "reflect for action" (p. 145). Schön explains this process as an "internal dialogue" (Stockhausen, 2006, p. 55) which is initiated in response to an unusual event. This enables the nurse to reframe the problem and draw from his/her experience to act on the event. This is particularly helpful in a medical field such as a mission, in which nurses can alter their practices as they encounter challenging circumstances.

However, "reflection-in-action" (Schön as cited in Stockhausen, 2006, p. 56) requires the existence of experience to draw from which many of the nurses on the mission did not have. Schön (Boud, 2001; Clarke & Graham, 1996) illuminates how reflection that takes place after the action may allow fuller exploration and critical thought, and I agree with him considering that this was when my most intense reflection took place. I also revisited my in action thoughts to connect them between other situations that occurred or reflections I had throughout the day and previous years in Kenya. Schram (2003) describes how when notes are reexamined out of the moment, additional thoughts may be captured, taking on a new significance. Leininger (2001c) also supports this continual reflection.

Although I originally wanted to maintain an unstructured approach to journaling due to the explorative nature of the qualitative inquiry (Creswell, 2008), I realized I required more than a descriptive account of participants' experiences in order to obtain

data applicable to the research question. Also, many authors agree that journaling should be structured in order to be more reflective than simply a diary of chronological events. Bankert and Kozel (2005), Clarke and Graham (1996), and Cox (2005) used a structured model to guide reflection for experienced nurses and adult learners and obtained valuable results from the perspective of the participants. Thus I asked the participants to consider: "What are your perceptions of working with people of this culture?" "What are some insights you have had around nursing within this culture?" "What are your thoughts around nursing on this mission?" while they journaled.

Since there are several levels of reflection, from descriptive to dialogical to critical (English, 2001; Hiemstra, 2001, Lasater & Nielsen, 2009), I hoped that participants would critically reflect on their experiences. However, many individuals, including me on the first mission, had no experience with journaling and found it "difficult to get started" (Clarke & Graham, 1996, p. 28). Clarke and Graham (1996) confirmed that even experienced registered nurses were unlikely to journal effectively without some direction. Two authors (John; Pearson & Smith as cited in Cox, 2005, pp. 462–464) used two different models of structured journaling from which I used facets:

1. What happened?
2. How do you feel?
3. What are internal and external factors influencing your reactions?
4. What does it all mean?

As the researcher, my journal was included in the data collection. Although some may consider this a potential for bias, I believe it was important to participate as a role model as well as provide a valuable contribution to the research. Cotterill and Letherby

(as cited in Walter et al., 1999) agree that researcher participation enables the researcher to "embed herself within the research to both affect it and be affected by it" (p. 14).

Focus Group Interviews

Upon return to Canada, once journals were transcribed and analyzed, a focus group interview took place with participants. This method was used to explore and clarify nurses' personal reflections (Rothwell, 2010) upon which they may have reflected in their journals. This also enhanced "face validity" by member checking (Guba & Lincoln cited in Lather, 2003, p. 191), which established trustworthiness of the data.

Once themes were generated from the journals, questions for the focus group were established to confirm and clarify any reflections as well as provide the opportunity for new themes to be identified. Leininger (2001a) supports an unstructured, open-ended inquiry to simulate the most natural method of dialoguing. See the Appendix for questions asked during the focus group. No notes were taken during the interview in order to imitate the debriefing sessions we have in the evenings after clinics during the mission. An audiotape was used to capture reflections and interactions during the interview.

Since the focus group was open disclosure, my lack of participation was essential to the validity of the study (Douglas et al., 2010), so I ensured I withheld my interpretations to enable nurses to present their emic thoughts (Leininger, 2001a). Thus my role in the focus groups was a "neutral advocate" (Schram, 2003, p. 101) in that I facilitated discussion and verified themes but did not actively participate as a respondent. Creswell (2008) identifies the importance of minimal researcher direction so that participants' voices are not constrained by the researcher's contributions. Rothwell

(2010) agrees that minimal involvement of the facilitator contributes to maximal participant interaction.

Methods

Prior to the medical mission, all nurses met as a group to discuss the logistics of the trip. During this predeparture meeting, I presented my proposal including the research topic, purpose, question, and methods.

I elaborated on the two phases of data collection, focusing on how the two methods together strengthen the research. My explanation involved a candid comparison of my past medical missions, one without journaling, one using journaling as a self-reflective, cathartic tool, and the personal growth I experienced through journaling. Neill (2006) describes how sharing personal and professional experiences with research participants establishes trust and reciprocity, which increases credibility of findings.

I emphasized the use of journaling for nurses' personal and professional growth, not just for my research purposes. I requested nurses to avoid using names or identifiers in their journals, hoping this may have minimized any sense of participants feeling they were revealing too much of themselves (Hayman, Wilkes, & Jackson, 2012) and contribute to open, honest, critical self-reflection.

If nurses were experienced in journaling, I encouraged them to journal in any manner they felt comfortable with to enhance personal growth and catharsis and to avoid limiting their self-exploration through enforcing a scripted approach (English, 2001, p. 30; Procee, 2006, p. 239). If they were new to journaling or unsure of the process, I reviewed the four steps described previously. These questions and steps were also outlined on the informed consent for them to reference at any time during the mission.

Following the mission, on return to Canada, participants submitted their journals anonymously into a basket, which I delivered to a prearranged transcriber. No names were on the journals as they were identified individually by colour or pattern. Once the transcriber had completed the transcription, the original copy was returned to each participant. This enhanced confidentiality and allowed me to analyze the data in a more systematic manner. This method also maintained the originality of the journals for participants to keep as a valuable memoir of their experience.

Once journal analysis was completed, all research participants were requested to submit their availability for the focus group interview. All nurses attended except one who did not respond and one who was not living in the area any longer. This took place at a participant's home and involved a comfortable atmosphere with food and conversation with the exception of the audiotape and display board to provide information and record the discussion. The display board exhibited the themes as indicated under Findings for nurses to refer to during the focus group discussions.

Nurses were reassured that I was the only one listening to the audiotape and would not be documenting any names or identifiers during transcription of these tapes. I informed participants that once transcription of the focus group had taken place, I would send a copy of the transcript to all participants to confirm the accuracy of the conversation and to add or clarify any points.

Confidentiality was assured by the agreement within the informed consent which requests participants' privacy and discretion with regard to other participants. This was also reviewed verbally prior to the focus group discussion taking place.

All nurses were informed they could withdraw from the research at any point by not submitting their journal to the transcriber, not attending the focus group, or informing the researcher following the submission of the journal/attendance at the focus group and I would remove their data from analysis and not include these in the results. They were reassured that they may partake in all present and future mission activities whether they participated in the research or not, and there would be no prejudice or penalty due to their decision.

Analysis

Jacelon and O'Dell (2005) describe five levels of qualitative analysis with the "gold standard" (p. 219) containing insight into the "breadth and depth of the phenomenon" (p. 220) studied. Analysis of data should also be congruent with the research purpose and questions (Jacelon & O'Dell, 2005; Knaft & Webster, 1988; Rothwell, 2010). Thus my analysis focused on the ways nurses' sense making and meaning making are affected by culture and context on the medical mission as described in their journals and validated in the focus group. My aim was not only to identify and integrate the themes discovered but also to fully explore the phenomenon of how these factors influenced professional practice during the mission.

Rabinovich and Kacen (2010) describe analysis as something that "reaches beyond the self-evident" (p. 706). Since my research method was inductive (Thomas, 2006), I wanted to ensure I was not only confirming what I identified as pertinent from my journal or past missions but uncovering others' perspectives (Jacelon & O'Dell, 2005; Mitchell & Cody, 1992) though different from mine. Therefore, I was cautious not only

to corroborate what was significant from my own experience but to discover original thoughts and ideas of nurses (Jacelon & O'Dell, 2005; Mitchell & Cody, 1992).

A large amount of information was obtained from the data collection methods. It was necessary to have a system to bring order to the data and to integrate themes identified between the data collection methods (Knafl & Webster, 1988) to fully explore hidden meanings (Jacelon & O'Dell, 2005). Leininger (as cited in Douglas et al., 2010) identifies the four phases of analysis as collecting, describing and documenting raw data; identifying and categorizing descriptors; analyzing patterns; and identifying major themes.

As I read the transcribed journals, I scrutinized the text for any themes that were related to the research question. In an open coding process (Creswell, 2008), I used post-its to note words, quotes, and text segments that stood out, were repetitive, related to the research question, and/or about which I just had a gut feeling. Rabinovich and Kacen (2010, p. 699) identify text segments as "units of meaning," and these were the words, expressions, quotes, and sentences that had meaning to nurses as they reflected upon their thoughts in their journals.

I reread the journals, highlighting words, quotes, and "text segments" (Creswell, 2008, p. 251) to compare if similar to those I identified on the post-its. As I reviewed the highlighted portions and compared the notes, I searched for patterns (Rabinovich & Kacen, 2010) to consider categories about the phenomenon being studied (Creswell, 2008), yet being cautious about my interpretation.

Once completed, I used flip chart paper for the axial coding phase (Creswell, 2008). At this point, I had over 100 text segments, words, thoughts, quotes, and phrases

as written by nurses in their reflections. As I wrote those words, quotes, and text segments onto the paper I looked for themes that were interconnected. It was apparent many words were repetitive and thoughts were similar. However, at one point, a divergent theme (Creswell, 2008) concerning team unity was identified as a contextual factor impacting nurses' experiences. Considering this was unforeseen and quite distressing, I attempted to externalize this by examining it as though studying the narrative to be objective about the matter (Kiesinger, 2002). Although many qualitative researchers and autoethnographers do not emphasize objectivity (Tillmann-Healy, 2002), I felt it was essential in this case to be neutral about the issue to separate my values from the inquiry (Seale, 2003). As I started recognizing patterns of texts, thoughts, and words, I combined them into lists without assigning the category yet.

Jacelon and O'Dell (2005) describe how interpretation is the second stage of the analytical process. Rabinovich and Kacen (2010) agree that this is examination of the relationships between categories. Careful consideration was required to deliberate how these themes were connected and how they related and changed with respect to one another. In this manner, I used a selective coding (Creswell, 2008; Rabinovich & Kacen, 2010) process to integrate categories and themes identified from the journals to summarize them into the major themes reflecting the research question and purpose.

In order to break the data into more manageable units (Jacelon & O'Dell, 2005), I was able to collapse the lists into themes under categories (Rabinovich & Kacen, 2010) which were related to the research question. I concluded with 10 themes associated with three categories: culture, context, and coping. Themes identified as cultural factors were women, people, patients, Kenyan nurses, Kenyan staff, and Canadian nurses "making

sense". Contextual factors nurses described were themes around team and Kenyan life. Bridging the gaps and feelings were identified as the coping themes.

In order to review for data gaps and inconsistencies, I took Bazeley's (2009) recommendation to "*Describe- Compare- Relate*" (p. 9) the themes generated from the journals. Through a narrative framework (McCance, McKenna, & Boore, 2001), I wrote the nurses' stories, which allowed me to examine the data in depth and identify focus group questions. McCance et al. (2001) describe how telling stories is a primary way of making sense of an experience. Clandinin and Connelly (1987) discuss how the narrative perspective allows one to focus on the meaning of actions from participants' personal and social perspectives which applies to the research question for this study. This is in view that humans "lead storied lives" (Clandinin, 2006, p. 45) by way of experience in relation with others and within a social context. I found story telling was an ideal strategy for this analysis as it helped me to create meanings from nurses' reflections as they attempted to make sense of their varied experiences while journaling. As I wrote the stories, I attempted to tie together the participants' experiences, relating common elements to understand their meanings (McCance, et al., 2001), and identifying gaps to pursue further with the focus group participants.

I introduced my journal findings to the focus group participants through a discussion and display board that exhibited the diagram of the themes. In this manner, the participants were able to visualize the themes during the group session and refer to them if necessary. Using an audiotape, I introduced the themes and asked the questions identified in the Appendix.

In an attempt to be a neutral participant, I had very little participation in the focus group and used the questions only to initiate or facilitate discussion and clarify and data gaps and inconsistencies. Following the focus group, I listened to the audiotape to transcribe and analyze the data. Rothwell (2010) describes how researcher transcription is significant to capture the nonverbal and emotional context of the group, and this may be relayed through tone and inflection of participants' voices as well as interactions between group members. Thus, as I listened to the tape, I not only transcribed the interview for content (Rothwell, 2010) but considered themes that emerged (Knafl & Webster, 1988) from the group members' interactions.

Rose and Webb (1998) advocate listening to the tape numerous times to gain an intimate understanding of the participants and a more "justifiable interpretation" (p. 560). Thus, after I transcribed the audiotape I listened to its entirety, repeating several portions over again. I wanted to ensure I captured the context as well as considered any new content upon which participants may have reflected further following their return to Canada.

I emailed the transcribed interview to the five focus group participants with a request to confirm, edit, or append any of the transcription. They were to reply within 10 days with any comments.

Following this, I reviewed the transcription, making memos (Creswell, 2008) about hunches I had from the audiotaped data and related to codes generated from the journal analysis or more broad and abstract thoughts. Maxwell (as cited in Schram, 2003), describes how memos "convert thought into a form that allows examination and further manipulation" (p. 26). This allowed me to connect themes generated from the

journals with those verbalized in the focus group. It also contributed to further insight and interpretation of the original themes generated. As I continued my analysis, I recognized one area I had neglected to explore further during the focus group. Since this was related to the divergent theme regarding team unity, I wanted to ensure I was capturing nurses' unique perceptions around this event. Thus I sent an email to all focus group participants asking for clarification of the meaning of this theme.

Ethical Considerations

Schram (2003) describes how engagement, involvement, and disclosure are essential aspects to consider ethical issues for qualitative research. My engagement in this research was evident during the premission presentation when I openly discussed my interest and passion for the research topic. Involvement is apparent, as I have been involved with CNFA for 4 years and three missions, as well as the fact that I am part of the sample with respect to journaling.

Disclosure took place during the premission presentation when all participants were fully informed of the study's questions and purpose. They were provided with past history of my experience leading to the need for this research. The nature and scope of the analysis and reporting were clarified to the best extent with focus that no individual identifiers would be used, as per the confidential basis of the research. They could choose to participate by signing the informed consent form following the mission with reinforcement that they could withdraw from the study at any point without prejudice or penalty (Schram, 2003, p. 105) and would still be able to take part in all of the present and future mission activities. The Brock University Research Ethics Board granted clearance for this study on April 4, 2012 as per file number 11-215-BROWN.

As with most researchers, my goal was to do greater good than harm (Schram, 2003). My intent to do greater good was not only by supporting the participants but by considering how nurses responded to the cultural factors influencing their practice with the goal to provide culturally congruent care (Mitchell & Cody, 1992). With this comes the identification of cultural issues that are so distinct from our usual practice that they may be conflicting to the participants' values.

The African HIV endemic has depicted the Black body as "diseased" (Brijnath, 2007, p. 371), with women as "vectors" (Higgins et al., 2010, p. 435) spreading infection to men and children. Brijnath (2007) cautions this portrayal of Africa as the dark, diseased continent, incapable of caring for itself.

Over the years I have made connections with Kenyan nurses, the community, and people that enable me to understand their worldview to some extent. Although no Kenyans themselves are part of the sample, the qualitative inquiry and ethnonursing method enabled me to construct meanings from situations and interactions with these people within the context of my mission work (Leininger, 2001a). Manias and Street (2001) agree that it is essential for the researcher to point out all aspects of textual accounts told from various positions, including the multiple voices of people within their culture. This was especially relevant for me as a participant in the research who was journaling from experience and as the researcher who is reporting results. Thus, although I would not be reporting on individual Kenyan people's perspectives, their voices may be heard in the context of the situation or an event.

My concern was in portraying Kenyans in a way that is perceived as negative due to their cultural diversity, since many aspects of Canadian culture are so different. This is

not only unethical but reinforces the fostering of dependence on others, which is contrary to Canadian Nurses for Africa's goal of empowerment and sustainability. hooks (2000a, p. 45) concurs with this, describing how some White feminists' notion is to "liberate their less fortunate sisters especially those in the *third world*". hooks (2000b) again substantiates this patriarchal attitude as even continuing into North America: the concept of Black women requiring rescuing by White women.

It was essential then that I remained aware of my own "positionality" (Brigham & Gouthro, 2006, p. 87; Douglas et al., 2010) in that I am the White, middle-class, non-Kenyan visitor to an area where I am perceived as privileged and wealthy. I was committed to make every attempt to relay results in a manner that did not portray Kenya or Kenyan people in a negative light.

Strengths and Limitations

Lincoln and Guba (1985) describe how credibility, transferability, dependability, and confirmability contribute to trustworthy research. Although the explorative nature of this qualitative inquiry permitted a naturalistic open discovery of experiences bearing on the nursing care provided (Douglas et al., 2010), this also contributed to the potential for bias in making inferences from situations and events. The strength of this research is that it is trustworthy, but the limitations are in the potential for bias in the analysis and interpretation of the data.

This research is credible in that direct quotations from the journals and focus group was used as evidence of "truths" (Douglas et al., 2010, p. 378S) as believable to the nurses reflecting on their thoughts. This thesis is written in a way that the narrative resonates with the reader, allowing them to live through the nurses' experience (Tracy,

2010). Thus findings may be transferable to any group of nurses on a similar medical mission. Dependability is strengthened by the "overlapping methods" (Shenton, 2004, p. 71) of journals and the focus group. Confirmability is evident by the "recurrent patterning" (Douglas et al., 2010, p. 379S) of different nurses reflections stating the same text and/or same meaning throughout multiple journals.

The verification of journal data by focus groups and confirmation of the audiotaped transcript by participants strengthened the results of this research, but there was still the potential for researcher bias and subjectivity (Schram, 2003) in the data collection, methods, interpretation, and analysis. Considering this, I have to acknowledge the possibility of my own values influencing interpretations (Douglas et al., 2010; Manias & Street, 2001). In hindsight, I may have had my findings corroborated through an "external audit" (Creswell, 2008, p. 267) to further strengthen this research.

Torsvik and Hedlund (2008) identify length of time the researcher is in the country of study as a positive factor to establish trust and build relationships. Similarly, by the fact that this was my third mission, I may have been considered experienced to the newer nurses, which may have enhanced trust and disclosure. However, alternatively, Ponic et al. (2010) describe how "power-over partnerships can readily and unwittingly dismantle even the best-intentioned research projects" (p. 330); thus I must recognize that my experience could have potentially be seen as threatening to nurses who may not want to be seen as incompetent or lacking confidence through their journaling or focus group disclosures. Even maintaining confidentiality for these data collection methods does not guarantee nurses did not censor their reflections (Rothwell, 2010) in fear of being judged.

Kavanagh (1993) and Sörlie et al. (2003) imply how nurses who are not confident comply with expectations learned in nursing which downplay nonconformity. Thus these nurses may have responded in ways the majority do instead of open, honest reflections, especially during focus group discussions.

On the other hand, some of the nurses have also been with the mission for 3 years and are considered friends as well as colleagues. Thus these participants may "over-identify" (Glesne as cited in Schram, 2003, p. 103) and respond to the data collection in ways they thought the researcher wanted them to respond (Rothwell, 2010). Nurses may have also chosen not to journal or declined submitting their journals for similar reasons. Hayman et al. (2012) agrees that one of the challenges of journaling is the participants "feeling exposed" (p. 27). Considering the team issues that were occurring, this factor may have contributed to either a lack of in-depth reflection or fewer participating in the research. In fact, I believe some nurses chose not to submit their journals and participate in the research for reasons around the divergent theme regarding team unity.

Schram (2003) describes how the researcher must present his/her role in the field appropriately, giving priority to developing and maintaining rapport with all. He identifies this as "boundary spanning, or developing relationships that transcend differences between groups or individuals within a setting" (p. 103). I was very sensitive to this issue during the mission considering the team issues that were occurring as will be addressed in Chapters Four and Five. I became increasingly cognizant of my place as the researcher, as I attempted to balance this with being a research participant, mission nurse, colleague, and friend. I will acknowledge that this matter may have affected participation in the research, open, honest reflections, and analysis and interpretation of results.

Limitations of the focus group method are the lack of documentation along with the audiotaping as well as the potential for disproportionate group participation. The lack of researcher documentation during focus group discussion was an effort to avoid stifling the creative element (Rose & Webb, 1998) of the nurses' dialogue by taking away the natural, normal debriefing environment. Dominating group members and lack of participation by individuals is a well-known barrier to focus group dialogue (Creswell, 2008; Rothwell, 2010), but that did not seem to occur in this group. I hoped that skilled moderation, enhancing group dynamics, encouraged nurses to engage in open communication and critical reflections. It seemed that all nurses in the focus group talked equally, with no restraints or inhibitions. In fact, they seemed to enjoy the opportunity to again debrief, and the group continued longer than the time planned. In previous years, the bonding and connections nurses made with one another during the experience of the mission contributed to a supportive group environment, which may have facilitated this.

Another limitation of the focus group is the potential for the facilitator to influence responses, albeit unintentionally. Although I attempted to be a "neutral advocate" (Schram, 2003, p. 101) during the focus group interview, I recognize it is truly impossible to confirm my body language or nonverbal expressions did not affect members' contributions during the group.

Researcher subjectivity does not occur only during data collection, but in analysis. Indeed Schram (2003) describes how this is always the dilemma of the researcher when using qualitative methods such as what to attend to, how to interpret it, and how our personal qualities and emotions influence the research process. It is impossible to

guarantee “value-free” (Brigham & Gouthro, 2006; Torsvik & Hedlund, 2008, p. 392) interpretation. I had to remain vigilant of the fact that the qualitative inquiry was for the purpose of discovery, not justification of my own preconceived notions (Jacelon & O’Dell, 2005; Mitchell & Cody, 1992) and attempted to be diligent about this matter throughout the analysis.

Summary of Chapter Three

Chapter Three describes how the use of the qualitative inquiry facilitates the exploratory approach which is aligned with the research question. Leininger’s transcultural theory and ethnonursing method further support this approach as it considers how nurses attribute meaning to the cultural factors they encounter as they provide care to the Kenyan people. Considering the critical theoretical basis, the aim of this research was also to examine how cultural and contextual factors influenced nurses’ usual practice.

As nurses journaled and discussed in the focus group, it was desired that these methods may provide a cathartic outlet for them as well as provide rich data for this study. Through critical reflection, nurses may have gained insight into their norms of practice as compared to the context and culture in Kenya and restructure their practice accordingly.

The strength of this research was that the data obtained was direct evidence from nurses on the mission from their personal perspective (Douglas et al., 2010). The limitations are the potential of censoring of reflections and disproportionate participation which may have been related to the divergent theme regarding team issues. Chapter Four will describe the results of this research and the meaning discovered from these findings.

CHAPTER FOUR: FINDINGS

"Once your eyes have been open, they can never be shut again" (D. Alchin, RN, personal communication, June 8, 2012). The findings of this research demonstrate the impact of the mission on nurses as they attempted to make sense of their experience and attribute meaning to their thoughts.

Introduction

It became apparent within the first few days of my first medical mission that although my focus had been on HIV prevention by using strategies similar to Canadian interventions, this issue was benign with respect to the overwhelming contextual factors affecting Kenyan people's lives. Although I had been encouraged to journal by a colleague, I felt too fatigued and overwhelmed and truly did not have faith in the process, so I neglected to do so. However, after critically reflecting through the use of journaling for an independent study during my second mission, I was able to identify my own despondency, hopelessness, and frustration due to the numerous factors affecting nursing care for these people.

The profound personal growth I attained from this experience contributed to my awareness of this activity as an essential component of the nursing mission, from both a personal and professional point of view. I have since become an advocate of journaling and hoped to encourage other nurses from my experience. Journals were a crucial component of this research to uncover the perspectives of nurses on this mission.

Emerging Themes From Journals

The themes that emerged from the study were interpreted in light of context and culture. As I relayed the nurses' voices through their stories, it became apparent how

coping emerged as a significant theme by which nurses dealt with these cultural and contextual circumstances.

Jacelon and O'Dell (2005) describe how it is a challenge to convey findings of research in a way that will be useful to the reader. In Figure 1, I have attempted to create a visual representation of the interrelationships that exist between the themes in the study. This figure portrays how specific cultural and contextual factors contributed to nurses' methods of coping with the mission experience through bridging the gaps and feelings. This figure provides a visual portrait for readers to come to a better understanding of the mission experience (Creswell, 2008; Ellis, Adams, & Bochner, 2011).

Culture

The most frequent documented reflections pertained to issues around culture. As nurses worked with and for the Kenyan people, it was and remained difficult for them to make sense of the experiences they encountered with Kenyan women, people, patients, and staff. Some responses were surprising to me, since I assumed cultural issues would be the most anticipated factor they would expect to encounter.

Women. It was apparent from nurses' journals that they recognized the obstacles for all Kenyans were more for women, as they were the primary caregivers. Often the men were away from home for long periods of time as they had to migrate for employment. In addition, cultural expectations were that the woman was responsible for the home and children even if the husband was not employed.

Nurses reflected about the chaos of triage, predominantly consisting of women with young children. They described how they would attempt to weigh children as they screamed in fear as the young Moms would attempt to lift each one onto the scale, often

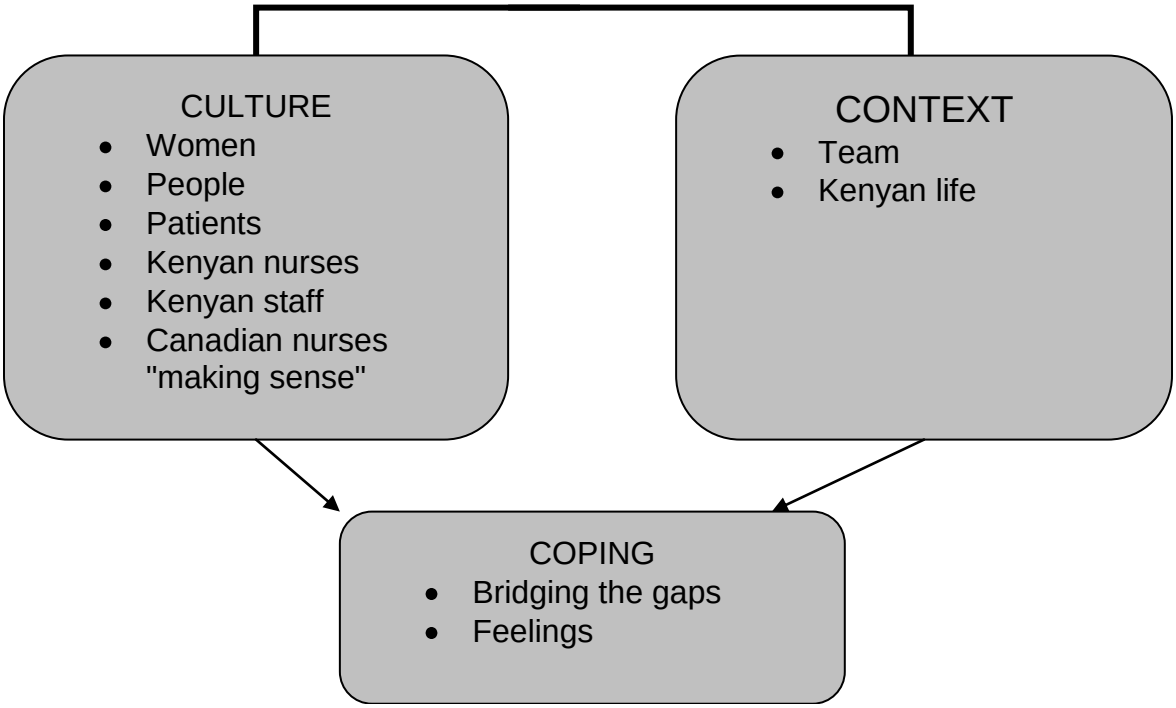

Figure 1. A visual representation of the emerging themes.

with another wrapped onto their backs, while breast-feeding the youngest. Indeed this was one of the stressors at the clinics, especially at triage, when the nurses would attempt to ascertain which children were with which women amongst the crowd, especially considering the multiple numbers of young children to each woman, often appearing one year or less apart in age and never with the same surname as the mother.

Nurses reflected on the difficulty of life for Kenyan women and felt they "suffered greatly." Being women themselves, the nurses said they felt empathic toward the Kenyan women, recognizing the trials they encountered in their daily lives. The women, who were ill and malnourished themselves, would walk for miles with multiple children in the rain and muddy roads to access clinics. They would stand in line for hours with the children to receive health care.

Numerous comments described the "hierarchy" of men before women and children, adding to the hardship for women. This was witnessed by most during lineups at and within clinics when men, especially those of authority (headmasters, politicians, church leaders, "chiefs"), were placed in front of others at clinics despite the fact that they were healthier. Interestingly, one of the experienced nurses who had traveled extensively working in various countries claimed this "pecking order" was the same in all countries, just "more blatant here."

The Kenyan helpers at the clinics identified the men who were to be seen first. At one point, two of us placed their charts underneath everyone else's. We were admonished for this. Although it made sense to us to triage according to acuity level, including women and children as top priority, there was an obvious acceptance by Kenyans that this inequity was not to be challenged.

Much of our experience with the women was validated by our interactions with the Kenyan nurses with whom we joyfully connected at times during and after clinics and learned from one another. Indeed many of the conversations were around our different worlds including male/female relationships. Nurses reflected on Kenyan nurses' comments that "men are very, very bad" as they described how married life often involved infidelity, abuse, and expectations of multiple children. One Kenyan nurse implied the reason men get married was to have children, and if the wife was unable to after one year, he would leave her. The significance of childbearing was very evident to us all, as most of the women who attended the clinics had at least four children, often close in age. I especially noticed this as I was the only nurse providing sexual health information on the mission that this research took place. During the sexual health groups, the women were more concerned about pregnancy than becoming infected with HIV. Since the use of condoms was obvious, the women were unable to negotiate condom use or even openly address sexual health issues with their partners. Thus they requested information on how to discreetly prevent pregnancy without their partners knowing. Canadian nurses discussed how the emphasis on family, relationships, and children did not make sense to us considering the legalization of polygamy and high rates of infidelity.

The hierarchy of men over women was defined as "men, women, children then disabled people." This became evident as one of the nurses reflected on how Kenyan women's needs would never be taken into consideration; because she explained that "basically the bottom line is if he's not happy, you're out . . . doesn't matter if she's not

happy" and that otherwise there were no options for women unless they were wealthy (i.e., divorce).

In attempting to understand why women marry, one of our nurses questioned the Kenyan nurses about this and documented this in her journal. Her answer was that parents could not continue to support their children; therefore as long as the woman was financially independent, she would not have to marry. Considering the cultural emphasis on family and childbearing, it would be surprising if this would be common. Also, taking into account the unemployment rate and poor income, most women could not be financially independent, so marry for monetary reasons.

Evidence of gender inequality was addressed frequently in nurses' journals as they gained knowledge from their interactions with the Kenyan nurses. Two nurses described how this matter was discussed with the youngest Kenyan female working with us, and how she disputed some of this, claiming the younger generation did not tolerate this inequity and men were expected to contribute to housework and childrearing in a fair and equitable manner. This was contradictory to the comments in many of our nurses' journals who documented that the Kenyan nurses indicated that men would not contribute to housework or child care even if they were unemployed. Since I had also reflected on the younger Kenyan woman's comment in my journal, I pursued this further in the focus group to question other nurses' thoughts. None of the Canadian nurses stated they noticed more equity in the younger generation of Kenyan women. Their thoughts were that this particular individual may have been more educated, affluent, or affected by where she was raised (urban versus rural Kenya), which enabled her to perceive an equitable relationship with men. However, it was acknowledged in the focus group that

the Kenyan nurses were also well educated, with comparable incomes and from similar areas; thus it did not make sense for these reasons to contribute to her unique viewpoint quite distinct from other Kenyan women we encountered. Perhaps younger Kenyan women do not experience similar inequitable relationships. It will be interesting to monitor this potential trend over time as we continue our annual missions.

Despite their hardships, many Canadian nurses reflected on how the women also had a "tremendous ability to laugh" and enjoy each other. I journaled about this during sexual health groups with women of all ages, with their multitudes of children sitting outside: how they were open in talking, asking questions, and giggling, yet they seemed very supportive of one another. Support was evident as they would care for the other woman's children as they participated in the condom demonstration. They would persuade quiet members to ask questions and participate in the discussion. The women would ensure all members received resources such as condoms and maxipads.

There was also a strong sense of comradeship among the Kenyan nurses. Those of us who visited their hospital reflected on how, despite the fact they were overworked (one nurse to 30 patients), had limited resources, worked in unsafe conditions (no safety engineered medical devices which are mandatory in Ontario), and had a large assignment of critically ill patients of all ages with two to three patients per stretcher, they "kept a great big smile and were kind to patients" and to each other. It was evident the bond among these nurses was strong as they would greet each other with a hug and handshake, "genuine pleasure to see each other".

To explore this further from a Canadian woman's perspective, I asked the nurses in the focus group what their thoughts were around this bond and if they thought

Canadian women experienced similar unity. All agreed that the Kenyan women had this unique bond that was very different from Canadian women's relationships with each other. Nurses discussed their thoughts around why Canadian women's relationships were different from Kenyan women.

One nurse felt that North American women do not require this type of unity as we have a more equitable relationship with our men; "they get support from one another as they don't get it from the men, where we do." One participant felt it was not only the inequity but the hardship that Kenyan women experience that reinforces this collective bond. A Canadian nurse elaborated on this, recalling her readings of groups of African women and poor women forming social action groups within their communities. Referring to White women's experience, one focus group participant disputed this collectivity, recalling her experience growing up in poverty in a farming community. Although the women got together out of necessity, they could be "vicious" about other women, and she felt this contributed to a more "competitive" nature with each other instead of unity.

Expanding this further, one nurse agreed that women are more competitive now, especially considering our power is "more recent." She described how her mother would use "persuasiveness and backhandedness" instead of assertiveness with her father. This nurse felt that women's need to manipulate to get what they wanted led to a more competitive nature overall.

Based on the comments of my participants, I questioned them if they thought there was more of a connection between White women in the past. Some nurses thought that because today most North American women are employed outside the home, there

was simply less time for women to convene and unite, as work and household chores take precedence over social gatherings. We all acknowledged that whatever the reason that facilitated the powerful connection Kenyan women had with each other, White Canadian women did not experience the same bond.

People. Canadian nurses journaled about the cultural characteristics of the Kenyan people. They were fascinated about some of these traits, yet frustrated by many others. The cultural differences nurses became aware of were documented frequently in their journals as it was necessary to rely on the people for many essential aspects of the mission.

Nurses described the Kenyans simply as "beautiful people" as they obviously enjoyed just being immersed in their culture. They noted how the "people of Kenya are a people of pride and they carry themselves with such" as evidenced by how they would dress well to attend clinics and church with our donated prom dresses, suits, and formal attire. The Kenyan nurses always looked immaculate, especially compared to how casually we are used to dressing at work and more often at these clinics, for our comfort. Despite that they would walk for miles or take the piki-piki (motorcycle taxi) or boda-boda (bicycle taxi) they always wore dresses and high heels to work with us.

One positive cultural attribute that all nurses agreed on was how everyone was willing to help anyone out, at any time or place. During our lengthy drive from Nairobi to Kakamega, our roof rack kept coming off of the van. We stopped along the roadside where a construction crew stopped what they were doing and came over to share their tools and to reapply the roof rack. We had a similar episode last year in which we

stopped for directions and the person hopped in our van, drove with us, stayed where we went to, and we dropped him off on the way back after.

Although to be admired, we had many frustrating times waiting for transportation, amending disorganized clinics, and readjusting our schedules to deal with "Kenyan time" issues. I could not assume this issue was related to Kenyans taking on other responsibilities which interfered with our professional practice, so I needed to clarify what meaning nurses gave to "Kenyan time" issues in the focus group.

"Accountability" was a term that was used in relation to this. Nurses questioned "who are we accountable to, our boss . . . the patient . . .?" They recognized how we put our schedules ahead of everything else. Nurses agreed "we live by accountability" where the Kenyans were "more humanistic when it comes to fellow man." Thus, within the group discussion, nurses seemed to agree that the "Kenyan time" issues we experienced may have been related to the difference in our orientations and recognized our priorities are less humanistic than theirs. We considered how "sadly" this attitude may change as Kenya is infiltrated with more Western influences and "the corporate world gets there and that's who everybody lives by."

Patients. Canadian nurses' journals demonstrated their compassion toward the Kenyans due to the overwhelming needs of patients during the clinics. However, as the clinic days went by, it was evident by nurses' reflections, that they were becoming frustrated by the constant requests and expectations of the patients.

Although they enjoyed the Kenyan people, when Canadian nurses became more fatigued and irritated, their comments became more notably frustrated, almost as if the honeymoon was over. Comments such as "Are the Kenyans opportunistic?" and "many

Kenyans take advantage" were noted. This was in reference to the donated items we distributed at the clinics; from colouring books and crayons, dolls, wooden cars, stickers, cloth maxipads and bags, the mothers would push their children forward to us, "give me, give me," often hiding they had one already to get another, wanting medications they didn't require, and continually asking for more: "want, want, want, want."

Despite the fact Canadian nurses were aware of the poverty and endless need of the Kenyan people, they felt taken advantage of because of the endless requests for "getting stuff—never ceases to disturb us all" or "noticing more and more the Kenyans' requests." One nurse was even accosted returning from the latrine requesting her shirt, watch, anything she had, just for the point of "getting stuff." After completing sexual health groups and distributing pads and bags for the women who attended, I would be swarmed by other women to also receive the same. I even had an elderly woman requesting maxi pads for herself despite she no longer menstruated. Often nurses made sense of the multiple requests by appreciating the gratitude from some people: "It's the people like him who are so forward and persistent about their gratefulness that really remind you about why you're here." However, since the requests were continual, it was difficult to maintain this attitude in response to the endless demands.

These "want, want, want" encounters were also related to the Kenyan nurses, who would befriend the new Canadian nurses to ask for jewelry, sunglasses, as well as being "hit up" for sponsorship by them, "trying to get with us to get out of Kenya." It was surprising to many who assumed they would be appreciative of the fact that we pay for our own flights and accommodations, raise money for medications from fundraising,

leave our families to attend the mission, and take vacation time to contribute to their people.

When questioned about the meaning they attached to the continual requests for "stuff" from Kenyan people in the focus group, all nurses vehemently agreed that the Kenyan people were opportunistic, but with reason. They identified three points that illuminated their opinions.

One reason was survival— "if I was in their shoes, would I not be doing the same thing? . . . it's how you feed your kids and yourself." The basic thought was that anyone anywhere would respond the same way to endure these circumstances.

The next rationale for the endless requests was wealth—how we are perceived to be "rich White women." A number of factors contributed to this. One point discussed was the fact that we can leave our country to go to another, which seems exorbitant to them (most have never been out of Kenya). Another factor nurses attributed to our perceived wealth is since we have greater access to inexpensive items, we are able to donate these without difficulty. An example given was the dollar store reading glasses we distribute, which all Kenyans ask for. The Kenyan nurses themselves were impressed by these simple items. It is true that there are no stores in the Kakamega area from which to purchase cheap merchandise. People survive on sustenance farming or barter for donated clothing and shoes from the marketplace.

Last, nurses described a "conditioning"—the expectation that White people go to Africa to provide aid. She described this as an "already established relationship." As we considered this in the group, I attempted to confirm what many had journaled about, which was "the potential for creating a welfare society similar to our own." The dilemma

we have had year after year is: Are we disempowering the people by providing free health care? And if so, what should we be doing then? This concern was a general consensus in the focus group and was discussed at great length. Though nurses were able to recognize our efforts towards sustainability through greater public health initiatives, we could all not help but question our interventions in terms of truly empowering the people.

Kenyan nurses. The cultural encounters with the Kenyan nurses were intriguing to Canadian nurses and they reflected on numerous situations with which they learned from one another. However, as many Canadian nurses journaled and discussed in the focus group, they noted the differences in demonstrations of care between cultures and between individuals.

Despite the Kenyan nurses' numerous requests, many nurses, including me, described how we enjoyed their "language and mannerisms." I would attempt to work in an area where I could interact with them more. One of the nurses even indicated, "I would like more relationship with the Kenyan staff, work more alongside them", in the focus group. I always enjoyed listening to them talk, "something I can't put my finger on, just different ways of interacting . . . murmer 'mmmh' in agreement" for example; "we say 'really?' 'right' or 'ya'", how they would laugh shyly, often avoiding direct eye contact. During morning prayers I would listen to them murmer and call out in agreement with the pastor's sermon and chants. Even with different religious beliefs, many nurses journaled about their appreciation of this time as they enjoyed hearing the dialogue between the pastor and the Kenyan clinic staff.

Their methods of communication were definitely different from ours, and although I enjoyed listening to their dialogue, we often discussed how, year after year, we have never gotten to know them better. They seem to be a very private people, not telling us about their personal lives or feelings, unlike when Canadian nurses get together; "Kenyan nurses are so different from us, who bitch and complain." One cannot help but consider how this relates to the lack of unity and more competitive relationships between Canadian women. However at times it made it very difficult for us to know what they were thinking, how they felt, and especially if work issues needed to be addressed.

One concern that came up, which has emerged yearly, is how despite the workloads the Kenyan nurses are used to, they never seemed to hurry. This unfortunately carried over to our clinic work, which was frustrating to some Canadian nurses who, being critical care nurses, were used to rushing from task to task, demonstrating their care through efficient service delivery. Some Canadian nurses accepted this as a cultural difference— "Canadian nurses could learn from these Kenyans," "Hakuna matata versus rigid Canadian time schedules and planning." As we attempted to be efficient to see as many patients as we could and to provide care to all, they did not seem to be concerned about the long lineups and waits of their own people. As nurses in the focus group attempted to come to an understanding of Kenyan nurses' apparent indifference to the ill people waiting, which contrasted their humanistic nature toward their fellow man previously discussed, they attributed their lax attitude to lack of caring.

Most people recognize that caring is the most dominant feature of nursing (Burhans & Alligood, 2010; Leininger, 1988; Rytterström et al., 2009). In addition, the cure dimension alone seems very limited in scope, viewing the patient only as a physical

being (Rytterström et al., 2009). We discussed how the Kenyan nurses' vast skills and knowledge gave them a sense of pride; "they see themselves as more competent than us." Some Canadian nurses described feeling "insulted" by this notion though others were able to recognize our staff–patient ratio is much better than theirs, which allows us to care for the patient with a holistic approach. In addition, though we felt we could provide better quality of care due to our focus on the patient as a holistic being, we had to recognize that their training has a different focus than the Western nursing education.

In fact, many nurses reflected upon the difference in nursing practice between Canadian nurses. From my experience, this is not uncommon, and occurs within Canada in various health care settings. On this mission and previous missions, some of us noticed differences between nurses who worked in critical care compared to public health and long-term care: "you can tell she's not an ER nurse." For example, critical care nurses tended to expedite patients through triage and work at a faster pace than those in public health. Those considered long-term care nurses were more meticulous with wound care than those working in emergency, where a gauze and tape is the extent of our efforts in the fast-paced environment. The public health nurses tended to spend more time communicating with patients, as their identity was based on nursing care as disease prevention and health promotion, mainly achieved through health teaching. Even between the Canadian nurses, journals indicated nurses were aware of the differences in caring amongst them.

As well as nursing experience affecting caring expressions, there were many times during this mission when I recognized the way I felt impacted my practice of caring, as it was the first time I had ever become ill on a mission. Other nurses had

verbalized this within their journals, especially as they became ill, fatigued, stressed, and run down.

It becomes evident that there are many factors impacting the provision and expressions of caring for patients. Thus, although during the mission our care translated into efficient service delivery to maximize patients treated, Kenyan nurses' demonstration of care was obviously different from ours. Perhaps their work alone on the mission was evidence of their caring. It is difficult to know due to the language barrier, as they spoke Swahili to the Kenyan people. It would be interesting to determine what the Kenyan patients' perceptions is of caring.

Unfortunately, without awareness of these factors, many of our nurses were not tolerant of the Kenyan nurses' work styles and reflected on their difficulty with it: "We deliberate these things back and forth with no answer." This is a significant factor to consider when planning premission education sessions and debriefing.

Kenyan staff. Although nurses' journals recognized the significance of working with Kenyan staff, they found many cultural aspects exasperating. They began to question the intent of the Kenyan staff, recognizing the overwhelming need of the people and their quest to procure financial incentives and social status at any cost.

When exploring the nurses' feelings around Kenyan people's assistance as staff and helpers during the mission, all nurses in the focus group agreed that it was "powerful to work with Kenyans" and part of the sustainability of our interventions. They were able to recognize that despite any frustrations, we had to accept the fact that we were guests in their country and had no right to place our North American expectations upon them.

However the journals spoke differently of working with the Kenyan staff. Frustration was described repeatedly, especially from nurses who arrived prior to the remaining team to orchestrate the behind-the-scene arrangements that were necessary for effective and efficient clinic work. Considering this organization required relying on our Kenyan contacts to coordinate people, transportation, and locations prior to our arriving in Kenya, we were "let down" by "undependable" Kenyans again and again. These nurses reflected their frustration by expressing thoughts of "banging my head against the wall" or stating they "pushed my last buttons," which ended in sentiments whereby we "can neither trust nor depend on him." No matter how evident the lack of planning was, it was ineffective to address it with the locals, once again because the communication was so unclear and there was no ability to address conflict directly with any successful outcomes.

It also became apparent to some of us (especially nurses who had been on previous missions) that these contacts seemed to be working with us in an attempt to impress others, possibly with an intention to pursue political leadership and attention in the community. One nurse started identifying one leader as "King" and "Your Highness" in her journal. One nurse reflected upon a conversation she had with a Vancouver resident who worked in Kakamega annually for many years; she acknowledged "everyone is out for themselves." This seems to be common in Kakamega, as many Kenyans describe how their leaders used to be good men, and then became deceitful in their intentions to help their fellow citizens.

Canadian nurses "making sense". Nurses seemed to embrace many cultural aspects of working with Kenyan women, people, patients, nurses, and staff, yet as they

reflected on them, they deliberated about the meanings, and consistently attempted to make sense of them through their reflections. Thus, though journals described specific cultural factors nurses were dealing with throughout the mission, it became apparent sense making was an independent theme distinguished throughout nurses' reflections.

Most of us attempted to understand complicated cultural factors such as the endless requests of the Kenyan people, patients, staff, and nurses, by considering the vast need of the people, how they had to fight for survival, and how we are viewed as "rich White women." Indeed it is no wonder they view us as "rich," since they are exposed to media images of our abundance of wealth with reality shows displaying big houses, expensive clothes, material goods, extravagent purchases, and spoiled children.

This became especially apparent as one nurse interacted with some Kenyan students who were "mesmerized by the White girl" and attempted to confirm all they had witnessed on TV and heard about North American Christmases, birthdays, Thanksgiving, and the material goods associated with the holidays. It seemed they attempted to "Americanize" themselves in admiration for us through their dress, clothing, "Americanized names with an African twist," and attire; "our girls love dangly earrings just like you love Masai"— an interesting comment indicating how we are all intrigued by cultures different from our own. This nurse's reflections seemed to make sense of their endless requests from us as an idolatry of our Whiteness, compatible with wealth and prestige, thus our ability to impart all of our resources to them.

One of the nurses journaled how, sadly, one of the young Kenyan female students stated, "White people are so much more beautiful than Black people." Indeed, it never ceased to bother me as I returned yearly to see how they would attempt to comply with

our White standards, especially how it was mandatory for the children to speak English at the schools or they would be punished if they reverted to their "mother tongue." As one newer nurse and I discussed and reflected upon, they would approach us speaking English in a stilted, stiff, nasal tone which we originally thought was how they were taught. However we recognized after hearing this at a variety of schools, from a few students, and with certain other mannerisms, they were actually making fun of us. We made sense of this by considering that perhaps this was an unconscious attempt to rebel against the enforcement of our language upon them.

As nurses attempted to make sense of working with people of Kenya, they also attempted to understand issues of working within the culture. Canadian nurses journaled about other various cultural frustrations: "They do not get: lineups, being ready, control, calming kids/being gentle, leaving space," and they have "no grasp or concept of line/staying in order." Indeed the ability to recognize who was first, second, third in line was compounded by the factor that they wanted to ensure they would be seen, "get stuff" (as described above) as they were well aware from past experiences and probably other groups that supplies run out eventually. However, nurses could not understand then why they "let others go in front, don't seem to mind." Often we laughed about this hakuna matata; no worries, no problem (Hakuna matata, n.d.) worldview when we ran out of gas as they would fill the tank only enough to get from point A to point B, not planning anything further than that. Many times we would have to admire this way of living as, despite the crazy driving on the roads where "two vehicles would occupy the same space at the same time," five cars would be driving the same direction on a two-lane highway, yet there were no road rage encounters, unlike at home.

One significant cultural factor that nurses described having difficulty making sense of was childrearing practices, including discipline and safety. Children were often alone in the community, near the dangerous roadside, walking for miles with other children, unaccompanied by adults. This was new to many considering the emphasis on child safety in Canada. One nurse admonished a mother for allowing her child to wear an item around her neck but fortunately was informed by another Canadian nurse who recognized this was a religious artifact which would protect them from evil; thus to remove it would be very disrespectful. The belief in supernatural, magic, "spells" and "hexes" was indeed very evident and nurses verbalized their concerns as they heard how parents would delay health care for their children to access witch doctors and folk remedies to "cure" them of the curse: "I struggle with what I feel is ignorance on part of the family jeopardizing the health and life of their child." The tribal influence was evident during the mission as people identified their illnesses as caused by "spells" and sought out witch doctors and herbal remedies before health professionals' advice. A nurse mentioned in her journal how the Kenyan Clinical Officers even verbalized their frustration when parents would delay health care for their children to seek out these traditional remedies to the detriment of their children's health. Nevertheless, this was their cultural belief and I would have assumed that the nurse that reprimanded the mother, who was experienced at home, would have been able to discern this as a cultural issue not to be imposed upon by her own beliefs.

Other nurses reflected on how the mothers would yank the child by the arm to lift them onto the scale. I also often witnessed mothers slapping their children during my classes and reflected on this, that somehow "it seems okay here where it wouldn't be in

Canada." Their "rough(ness) with their children" was also mentioned in the focus group, but this nurse was able to associate the meaning of this as cultural differences in childrearing. Thus some nurses were able to recognize this as cultural diversity, and some were not. It is apparent how it was difficult for some to distinguish between distinct cultural practices as opposed to the best evidence guidelines we are used to practicing with in Canada. However, this may create the opportunity for learning from one another. This is another valuable result to consider when planning mission activities and our clinic days.

It becomes apparent that the numerous cultural characteristics that we deal with contribute to both positive and negative experiences. Nevertheless, it is essential that we consider that we are guests in Africa and must work within Kenyan culture, not enforcing our own values upon the people. It appeared, through the reflections, that some nurses were able to make meaning of this, but a vast majority was unable to comprehend this fully enough to restructure their practices.

Context

Team and Kenyan life were two themes that came forth in nurses' journals. These were identified as contextual factors influencing their professional practice during the mission.

Team. Team became one of the most significant themes under contextual factors impacting nurses' sense making and meaning making during the mission. This theme had an unforeseen outcome which was unanticipated by many nurses especially those involved in previous missions.

In the earlier sections of the journals, which were focused on the initial mission activity, many nurses identified a sense of togetherness, beginning with the excitement of starting the journey to Kenya together, traveling to Kakamega, and the commencement of the clinics. They spoke of a "connection" described as "whole group together, getting together, working together" and identified the feel of "team." A sense of camaraderie was described as nurses "working together with a common goal and purpose to help Kenyan people."

As nurses worked together with this commonality, a "pride in nursing" was described with a feel of "like-minded colleagues, we can truly branch this divide between our countries and our people." This also gave a sense of inspiration to team members as they debriefed in the evenings and were invigorated by their common concerns for the Kenyans. This commonality was expressed very strongly in the focus group as well: "Our focus is the same . . . we are all there for the same purpose, the same reason . . . we're all on the same plane." Some nurses also spoke of a sense of female bonding, having fun together, sharing stories, and "never a dull moment when you are with a bunch of RNs."

However, it was noted by some that there was a change during the week: "disturbing events – fragmented group, excluded many, suspect much negativity has been said." This was described as a subtle negative impact on that bond that was initially noted. It was further described as an exclusion of some nurses, causing "fragmentation" and "splintering of group." Much concern was voiced in the journals about the impact of this "infecting" the group, which "put a damper on the bond." In the journals there were multiple entries describing this fragmentation. It was more frequently noted by those

who had been on the prior missions as they journaled in an attempt to make sense of this division, which had never occurred before. I do have to acknowledge that the nurses who seemed to be involved in the fragmentation did not submit their journals or participate in the focus group. The two nurses who had journaled about the division were present in the focus group but were viewed as experienced mission participants. This may have put them in a position that made them feel uncomfortable to openly address this issue during the focus group with newer nurse participants present. Therefore, the results of this matter may be biased by not including the majority of the participants' reflections on this significant matter.

The dissension had a profound impact on the nurses who reflected upon the matter as they concurrently expressed "concern" consistently throughout their journal reflections, as division within the team had not been an issue on the three prior missions. The team issues were covert and difficult to pinpoint; however, there was a strong sense that the team bond was not the same as it had been initially. Since the discord was felt through subtle negative behaviours, nurses pondered if the behaviours were in fact evident to others and/or troublesome to anyone else, or they questioned whether it was just their oversensitivity due to fatigue and stress. We began to question our own judgment and could not come to a conclusion about how we should handle it. Thus unfortunately the issue was not addressed. In their journals, two nurses reflected, "could I have prevented this?" On consideration following the mission, one may recognize this as evidence of culture shock. Authors (Adler, 1975; Brown & Holloway, 2008; Stewart & Leggat, 1998) describe how the initial response to working with a different culture is characterized by excitement and euphoria which is followed by a stage of crisis. This

crisis stage is evidenced by various behaviours such as frustration and indignation with minor issues, anger, and hostility. This is succinctly what occurred in this situation. In retrospect, the nurses who recognized this conflict realized after the mission these behaviours should have been addressed immediately instead of allowing it to proceed and potentially deteriorate team functioning.

I was one of the nurses who sensed the dissension and can confirm the tension this issue caused. Considering that I often use humour to relieve tension, I was concerned that a joke I had made was taken out of context and the division was actually caused by me. With this I became acutely aware of the extent of this issue and extremely sensitive to the atmosphere. I ruminated about it frequently with concern that I had unintentionally sabotaged my own research. I admit it caused me many sleepless nights as I reflected upon this matter. The four nurses who had felt this division debriefed about it and each felt we may have done or said something that caused this rift. As the researcher of this present study, I became quite concerned of the ethical nature of this situation, and attempted to be vigilant in preserving the remaining team relationships.

Considering the sensitivity of this topic, I admit to the difficulty I experienced addressing this issue within the focus group. However, I did describe how the theme of team came up as a positive and negative aspect for some participants in their reflections, and I carefully worded my question in the following way: Did the concept of team affect your practice during the mission? Interestingly, not one nurse concurred that she had felt this division. As a matter of fact, one nurse indicated how it was not different from our work environment at home; “we may not agree with what someone might say or do but you have to learn to get along.” I believe she was aware of the team dissension, even

during the mission, but made sense of this by acknowledging how "people come from different backgrounds and some may have expectations of things being done a certain way and some are open to being told what to do." Others described the team in only a positive manner: "What impresses me about people (Canadian Nurses) when we are there, [is] how selfless they are."

One comment that came out in the focus group was that all nurses participating on the mission had "strong personalities; otherwise we wouldn't go." All nurses in the focus group vehemently agreed with this statement. This reflection is very plausible considering the emotional and physical toll of the travel and work. However, when considering the context in which this theme was addressed, the question was attempting to make sense of the team dissension. Perhaps I could have been more explicit in my exploration of this theme, and unfortunately, at the time, I did not determine what "strong personalities" meant to the nurses. However, since the team issue was unique to this mission and unexpected, I wanted to explore what "strong personality" meant to each nurse so asked for clarification in an email following the group.

A consistent response was the word "leadership" and "not afraid to take charge or take on a challenge." Some nurses were more descriptive: "definite in their convictions, will follow what they believe to pursue their goals instead of going along with the crowd." Others acknowledged "a strong personality is one that imposes their will on the group therefore may change or add to the group's focus in either a positive or negative way," and "could be someone who is used to getting their own way and will work very hard to get what they want at the cost of others." The latter statements were especially

relevant to the sense of team division because the ringleader seemed to instigate disruptive actions when organization of the clinic was not done the way she preferred.

This is succinctly what occurred on the mission. One nurse in particular, who was in a management role at home and often undertook leadership tasks during fundraising, presumably having a strong personality, was a significant contributor to team dissension as addressed in some participant journals. It was noticed through reflections on how she seemed to isolate specific nurses, segregating certain members against others, which contributed to the team division.

Fortunately, the team dissension did not directly affect the care given to the Kenyans but did affect clinic work. For example, communications seemed forced and not relaxed and open as it had initially been. Cliques of nurses began forming with the insistence of only working with specific individuals. Some nurses journaled about the "teenage high school girl behaviours." Thus, for some, the team division decreased the personal satisfaction from this unique experience. However, the extent of the impact of the dissension some participants experienced is unknown since not all nurses reflected on this team division in their journals. In addition, newer nurses would not be able to compare this particular team experience with previous mission experiences.

A new perspective that was identified within the focus group was that one nurse would have liked to have more of a team connection with the Kenyan nurses. Although she felt very much a part of the Canadian team of nurses, this was not so with the Kenyan nurses. However, not all focus group participants agreed with this. Through discussion, it was determined that she participated in five clinical days whereas the remaining nurses completed 11 clinical days. Those who participated in the full mission had been involved

in the team building supper with the Kenyan staff and had more time to connect with them on a personal and professional level. However, this could be valuable information when considering nurse participation for future missions.

Kenyan life. Frequently through their journals, nurses described the contextual conditions affecting the lives of Kenyans. From the health and welfare of the people to the environmental conditions, and the political and social structure, nurses recognized how complex and multifaceted the issues within Kenya are.

Nurses continually reflected on how Kenyan people's lives were difficult "in so many ways." They made comments like "reality is harsh here." There was recognition of the many "obstacles" and "roadblocks" in their lives, with examples from lack of employment, insufficient access to health care, inadequate health "resources," and comments such as there is "so much rain," that leads to "potholes" in the roads, which led to comments about "the way they drive [it is] best not to look out the window." These comments were identified as barriers contributing to the struggle in Kenyans' lives. It is true we had many stressful situations driving to and from clinics with 17 nurses in a 10-seat van on the muddy roads, with pouring rain coming down as we tipped from side to side. In these moments we literally prayed for a safe arrival.

Nurses especially described the state of the children who were "poor, emaciated, malnourished, tattered, [and] threadbare." These comments were probably made because we are not used to seeing children in such poor health. It was evident that "kids [are] forced to grow up here quickly" as the participants noted children caring for children. This is probably because of the high dependency ratio due to orphaned children (Kahuthu et al., 2005). Often one child would bring his/her siblings to the clinics for health care,

unsupervised by any adults, and would take responsibility for their his/her health care and medications. Poverty and "neediness" came up numerous times, but they also surmised that people "do so much with so very little," one example being requesting the empty pill containers and boxes from our clinics so they could store any of their grains or water in these containers.

Nurses reflected how Kenyans were "vulnerable to police dominance and control" as they noted the spikes on the road that police used to stop vehicles and question people, including us. However, corruption was often covert. One "never know[s] where it is"; for example, in our multiple police stops on the way to clinics we were not sure if bribery was involved or not. When we questioned our Kenyan helpers about what the issues were and/or what the police were looking for, it was difficult to get a straight answer, and many nurses reflected on the lack of communication, whether it was intentional or not or perhaps because "we are White," or whether it was a safety issue for them, or whether they accepted the deceitfulness with resignation.

However, nurses also reflected on how many of the Kenyans spoke openly of the government corruption, yet when the Deputy PM campaigned, they rallied around him, chanting in admiration. At one point we were delayed by a parade of cars from one political candidate who, with his entourage, posters, and megaphone, drove slowly down the road as the people crowded around cheering for him. As one nurse journaled: "lots of promises of help but little comes through." It became evident that the nurses were beginning to understand how one has to be vigilant about the provision of charity.

Indeed, there was recognition by nurses of the dichotomy within Kenya as they reflected on the wealth in Nairobi and saw some of the leaders' homes near Kakamega:

"within Kenya land of extreme, rich and poor, beauty and unsightly." Some reflected on how although everyone in Kenya is "worse than us, Canadians, even in their worseness there are levels." Some made sense of this by acknowledging since we, Canadians, are mainly better off, it was our duty to help. "Why won't people on our side wake up and do something?" Many nurses seemed to embrace this belief.

One new theme that was addressed in the focus group by a nurse who was a seasoned mission participant was that the people appeared to have more hope on their faces than they did in the initial year of the mission. "I look out now and I think something has shifted and I think what it is, is hope." It seems that the anticipation of the same group returning year after year established trust in the people. It was noted that many other groups would leave with promises of aid, and then never return again. This was noteworthy considering our concern of generating a welfare society and disempowering the people; "they see themselves as nobody, see themselves as nothing, unimportant . . . they get blown away by us White women coming back year after year, to help them." Perhaps this demonstration of care alone is empowering.

On the other hand, one newer nurse noted how she felt resentment from some patients. Another nurse described this mainly in the young men in the town, which she had noticed on a previous mission. She stated: "The young men, you know, they get it, they really get it, haven't got a future, not a job in sight." It was apparent how groups of young men would "hang around" all day in the town, gathering without purpose, with no money to enjoy life due to lack of employment opportunities.

Coping

As Canadian nurses attempted to make sense of the cultural and contextual issues they were dealing with in Kenya, their reflections indicated that they continually noticed the contrast between the two different worlds. As they attempted to make sense of the contrast, they used reconciliation and rationalization to bridge the gaps (Teekman, 2000) they were experiencing. Nevertheless, these strategies were not entirely effective to help them cope; thus one of the primary themes that came forth was feelings they themselves expressed and what they noted in other team members.

Bridging the gaps. As they attempted to make sense of atypical experiences on the mission, gaps were identified by nurses. It became evident throughout the journals how nurses attempted to cope by bridging the gaps of their inexperience.

Nurses reflected on the differences between Canada and Kakamega using the word "contrast" repetitively, counted at least five times in different journals. The term juxtaposition also was used in various journals, an interesting term which made sense since it was used in reference to the direct comparison of Kenya and Canada, described as "disparity between them and us" but sometimes generally "discrepancy in the world."

The nurses contrasted various factors from the culture and context of Kenya to the customs of the people. Most of the comparisons reflected health care issues such as lack of resources, inappropriate interventions, ineffective provision of health care, and access to suitable health care facilities and resources.

As nurses traveled from Nairobi to Kakamega they journaled about the differences in the settings of Kenya and Canada. They especially noted the "unsanitary" conditions, "food, clothing, shoes covered in dirt", and recognized this as "such a contrast

in lifestyle" from what we are used to. With this they considered the factors impacting the health and safety of the community and its people: "two transport trucks in a ditch . . . truck drivers expected to drive two days without sleeping or they would be fired." They compared the law enforcement and recognized the corruption: "we got hauled into the police station because our driver forgot his license, he would have 24 hours to get this at home." However they were surprised that despite the hazardous drive from Nairobi to Kakamega, there was "no road rage" when they cut drivers off on the highway and fought for parking spots and entry onto the road instead of "politely merging." Although their comparisons indicated inadequacy in the standards compared to Canada, they realized the Kenyans accepted their way of life and did not question the customs they were used to.

One discrepancy nurses felt was that there were not enough resources for everyone at the clinics, which did not occur in Canada: "made a splint and shoe out of cardboard, can be creative with very little." On the mission we would often see almost 1,000 patients per day in comparison to triaging a maximum of 100 patients a day in the hospital I work in. In fact, we treated over 14,000 patients in a 2-week mission in total. Since we provided free medications, wound care, sexual health education, and the opportunity to receive items such as children's toys, baby clothes, and maxipads, supplies would eventually run out by the end of the day. It was impossible to have enough provisions for everyone. Nurses knew that in Canada it is unusual to deny anyone health care.

The inadequate resources were also documented by the nurses who had visited the hospital: "had only one working cardiac monitor, young man with meningitis with no IV." This was unfathomable to ICU nurses who were used to working with all of the

technology to monitor a critical patient's status. I was shocked to find at a volunteer counseling and testing site they had no more kits available so were unable to test anyone for HIV. This was alarming to me considering the HIV rates in Kenya.

In addition, the acuity level of the patients could not be designated as similar to in Canada. Many children we triage in Kenya would be rushed into the trauma room immediately and identified as "critical" in Canada. This made nurses doubt some of the treatments ordered: "give antibiotics that may not be needed yet didn't order Tylenol when it should be" and question the ethical nature of their interventions "on one hand we are correcting a problem, on the other hand it's legally out of our scope of practice." It was impossible to respond the same way we did at home as we did not have the resources to support these concerns.

Many nurses reflected on their "bandaid solutions," similar to applying a simple bandage to an infected wound without cleaning it or treating it to prevent further infection. This was evidenced by their descriptions in their journals of the limited resources they could provide, the short-term treatments, and the effectiveness of their strategies "to improve the health of Kenyans . . . so much bigger than we can offer" as they attempted to make sense of our interventions.

Not surprisingly, the dilemmas they described were often in reference to accessing health care, how Kenyans couldn't afford health care, and couldn't access it. One participant stated, "the more you pay, the better care you get" then referred to how lucky Canadians were to have accessible health care: "how awful it must be to not be able to go to Shoppers and buy some Tylenol for your child's pain." Nurses recognized their own vulnerability, realizing that is was "simply luck that we're born in Canada versus

here" and comments such as "I just had a fair chance as that baby of being born in Kenya; Just got luck of draw," and finally, "if he had been born in Canada he would have such a different life ahead of him." With this some nurses reflected: "Do most Canadians appreciate where they were born and blessed with the comforts God gave them?"

There was an overt recognition of how life was difficult in Kenya compared to Canada. This was especially so for women and children. This was particularly in reference to Canada's priority given to women and children, where, in Kenya it was overtly evident how "men were before women and kids" and how children took care of children, with realizations such as "life is hard for everyone here, even little ones." One nurse journaled how she spoke to a Kenyan nurse about the lack of parental supervision for young children at the clinic and she replied "as long as a child is over five they can speak for themselves." This was such a contrast to childrearing in Canada as this nurse recognized how it would actually be considered negligent to send a child of that age to access their own health care.

In the focus group, the same inner conflict was verbalized again. The term "struggled" was used repeatedly. It was evident the same issues continued to contribute to nurses' internal dissension after arriving home: "mulled over and over since we came home." Despite that my question intended to explore what could help them with their feelings, nurses continued to confer back and forth, similar to their reflections in the journals, with no conclusion. It was apparent they still needed to attempt to make sense of their experiences within the complex social and cultural environment we were working in. After a time period, one nurse exhaustedly indicated, "It's interesting when we get back and talk we're still stewing about these issues!"

Thus, as nurses compared how they would respond as a Registered Nurse in Canada but were unable to in Kenya, they recognized ethical issues around turning people away from clinics as medications ran out and the inability to provide the same care as they would in Canada. This was realized through comments such as "what is acute to us is not to them," and there is "never enough to give, not able to see everyone." Their own struggles with inadequacy became evident through their normal role of nurse as caregiver and provider.

Numerous comments identified how nurses made sense of the differences between Kenya and Canada through reconciling the contrast by recognizing "rewarding" experiences such as I "saved life or limb of 10 people today" or s/he "wouldn't have made it without our help." They also rationalized by acknowledging their limited resources by acknowledging, we "do what we can with what little we have" or clearly stating, I "can't help everyone." They also mentioned that it "feels good to help where we can" or realizing that "we did some good." Thus as nurses attempted to cope in this unique environment with unusual experiences, they bridged the gaps they were experiencing by using rationalization and reconciliation to make sense of the contrast between Kenya and Canada.

Feelings. Bridging the gaps through rationalization and reconciliation provided temporary relief for nurses to deal with the overwhelming circumstances they were encountering. However it became evident through the journals and in the focus group that these coping strategies were not sustainable and overwhelming feelings lingered with the nurses even following the mission.

Nurses' attempts at coping came with a sense of feeling "up and down emotionally" and "the last 2 days have left me with so many emotions" and finally, the recognition of the toll on their emotions: "Can I keep doing this year after year?" The most consistent text that came up was "overwhelmed." This word was also used frequently in the focus group. They did describe this in the physical exhaustion of the clinics: "physically taken to my limits" due to the never-ending lineup, long clinic hours with no breaks, clinic environment, describing the "room close with bodies, air heating up, all of us sweating, shouting at each other over the med table" which was compounded by poor sleep, illness, and fatigue. However the sense of being "overwhelmed" was mainly related to encountering situations more profound than nurses had ever seen in their lives as they were "stunned by condition of children." This moved one nurse "out of [her] comfort zone," and remarks such as "I gasped when I saw him" or "I don't think I'll ever forget the sight of him, [it was] one of the most disturbing things I've ever seen" were shared in the participant journals. The implications of this are concerning considering that some nurses expressed "having some serious second thoughts whether I could handle it" and "I'd be lying if I wasn't worried about making it through the next two weeks."

Although nurses attempted to cope by reconciliation and rationalization, generally, most of the time they described feeling "sad, sad, sad" and that the conditions "tugged at heartstrings" and nurses were "heartbroken every day at clinics." Through it all they became "emotionally exhausted" and ultimately realized they were unprepared for the emotional impact of the circumstances. This experience "impacted me harder more than anything I have ever seen", even "more than I ever imagined." I "wasn't

expecting clinic to be as emotionally and physically draining." This led to difficulty in reincorporating back into their "normal" life following the mission.

In the focus group, all nurses agreed how they had difficulty coping on their return to Canada. On attempting to redirect them to the initial question, they felt "nothing can prepare you." They could not even talk to other people about their experience to help cope with their feelings since there were "no words for people who haven't experienced it." One nurse even indicated she avoided people at work and took breaks alone as her frustration grew with what she now deemed as "mindless conversations, our focus is so ridiculous, do we need this stuff, we're so busy with the wrong things."

One can see how overload and this unique mission environment contributed to the gaps as nurses attempted to make sense of the atypical situations they were encountering. As some started second guessing whether they would be able to continue dealing with the circumstances, they expressed feeling at the "end of [the] rope." One woman journaled; "I ended up crying . . . it just needed to come out . . . I didn't realize it was there. I think emotionally the worse is yet to come and it scares me." In the focus group, another nurse recalled how, after returning home to Canada, she was watching a movie which reminded her of the Kenyan children and she started "bawling my eyes out … it came out of the blue . . . I thought it didn't bother me at first."

As well as feeling sad, some nurses even exhibited anger in their journals. One participant stated "coming from a place where health treatment is everyone's right this is unfair and heartbreaking. Why won't people on our side wake up and do something?" As this nurse expressed frustration she recognized how Canadians do not appreciate their

abundance. Some made sense of this inequity by acknowledging that since we (Canadians) are mainly better off, "our duty is to share and open ourselves to our less fortunate brothers and sisters." If we just "look inside ourselves (Western privileged nation) we can see our duty is to share with [the] less fortunate. For that is the path to wholeness for us rather than feed into the consumerism and selfishness our culture expounds."

It seemed experienced mission nurses noticed the difficulty of their team members' emotional vulnerability, "noticing others sick, on edge, tired, fatigued, exhausted," and described them as appearing "shell shocked." This was a concern since we recognized how it was more difficult to cope with these emotions when you get run down. It was duly noted that there was a "need to be healthy to cope here." In response to their concern for their colleagues, experienced mission nurses, including me, felt they had to appear better able to cope than those new to the mission: "talking incessantly to deal with emotions – I have to put them aside to be effective," so they could be supportive to others who weren't coping well. I became ill for the first time during a mission, and very aware that I did not want to appear so; it was a sense of having to appear stronger to compensate for others who, understandably, would be unable to do so.

Nurses new to the mission were more vulnerable to the profound emotions, and one described having a "meltdown." Another described having an "accumulation of grieving that was put aside the past two weeks." Another participant stated, ". . . it was the trigger to an emotional outburst I didn't know was coming." Indeed there were many times I could feel tears rise as I triaged an ill patient, and this would often occur during unexpected situations, both good and bad.

The team issues that were occurring compounded our concerns for our newer colleagues. We recognized how essential it was to have a connected team and supportive colleagues to sustain each other through these trials. In the focus group, many nurses agreed that they needed to vent with each other, probably because their common experience connected them emotionally. In fact, they almost seemed to resent others' inquisition into their experience, inferring no one could truly understand what they had gone through. I would concur with this as I felt exactly the same frustration, especially after the first mission, although I learned to adapt following subsequent missions. It seemed almost essential for me to reconnect with the mission group soon after returning to Canada while dealing with these intense emotions as this approach felt the most therapeutic to me. Gaw (2000) identifies the difficulty reentering back into one's culture after a cultural experience as "reverse culture shock" (p. 83). This information is helpful when considering the implications for this research.

Meaning of Findings

The themes that emerged from the journals were corroborated by the focus group interview with the nurses. As nurses worked within the Kenyan culture, they described the hardships that the women experienced, yet the strong bond that united them, as well as the joys and perils of working with Kenyan people, patients, nurses, and staff. It was evident some began to critically consider their own privilege and "Whiteness" as they attempted to make sense of these cultural experiences.

Nurses reflected on the context of the medical mission, in which it became apparent how essential a united team is to provide support to one another in this unique environment. From my experience over the past two missions, some of these themes

were not surprising to me but only served to reinforce how nurses make sense of the unique experience of a medical mission.

The results of this research are of greater significance than I had anticipated. The previous two missions I experienced were exhilarating. However, numerous factors as described in the findings altered not only my experience but other nurse participants' as well, which was evidenced in their journals as they tried to make sense of their experience. The intensity of the emotions the nurse participants experienced became even more palpable during the focus group. The main outcome, coping, communicates the necessity of education and emotional support for nurses prior, during, and following the mission.

Summary of Chapter Four

Chapter Four presents the outcomes of the research exploring nurses' sense making and meaning making as affected by culture and context during the medical mission to Kakamega, Kenya. It also demonstrates how these cultural and contextual factors influenced the nurses' professional practice.

It became evident from the results, as nurses attempted to make sense of their experiences on the mission, cultural and contextual factors contributed to their meaning making. These factors not only influenced their nursing practice, but led them to experience some of the most unanticipated, profound, sometimes distressing, and often inspirational circumstances they had ever encountered in their personal and professional lives. As nurses confronted these unique situations, they attempted to cope to the best of their ability, with strategies with which they were not familiar. This contributed to

overwhelming feelings, often of great sadness, with which they often had difficulty dealing.

Nurses reflected on women, people, patients, Kenyan nurses, and Kenyan staff as they attempted to make sense of working within the culture. They noted how the inequality of men and women placed a great burden on the women, yet this injustice seemed to be accepted with resignation by all. Despite their burden, Canadian nurses reflected on the connection between the Kenyan women and became aware of the powerful attribute this bond contributed to.

As Canadian nurses worked with the Kenyan people, some frustrations were identified. Initially they described "Kenyan time" issues impacting on their ability to provide organized service in the clinics. However, upon exploration, they were able to make sense of the differences in "accountability" of Canadian nurses as compared to Kenyan nurses. This led to personal and professional growth, as they were able to attribute meaning of their own accountability as less humanistic than the Kenyans' priority to their "fellow man."

Although Canadian nurses were aware of the desperation of the patients they treated, they became less tolerant over time due to the numerous demands placed upon them. They were able to make sense that their patients' frequent requests were due to the ongoing hardships in their lives. However, this led to further questioning of the effectiveness of our interventions and treatment provided for the people we served.

Canadian nurses valued working with Kenyan nurses and staff but reflected on differences in work styles impacting the clinic efficiency. Some were able to acknowledge and accept these differences, but many nurses had difficulty working

around this. It seems that caring plays a significant factor in this, especially with differences in demonstration of caring both culturally and individually. Further research exploring the meaning of caring, for the Kenyan patients we serve would be an interesting avenue to pursue.

As Canadian nurses attempted to make sense of the cultural influences on their practice, some were able to acknowledge their own "privilege"; this in turn inhibited them from accepting the differences and working within the culture. The Kenyans' attempt to conform to "Whiteness" reinforced our perceived superiority to them. They see us as being wealthy and desirable. As nurses explored these cultural traits, I had hoped journaling would increase their ability to critically reflect in order to alter their professional practice to become more culturally congruent. Unfortunately, this did not seem to occur to the depth I had desired.

Through team support nurses were able to make sense of the cultural factors they were having difficulty making sense of. Although this was identified as a positive element, some nurses experienced a change in the team connection, which they described as a "division, splintering, and fragmentation." This significant theme was a huge concern since, as described in some nurses' journals, it had never been encountered on any of the past missions. Although it was an extremely distressing experience for some nurses, it eventually was recognized as a potential for personal and professional growth for nurses and CNFA as an organization.

Nurses described that they had difficulty making sense of Kenyan life as they recognized the dichotomy of their own worldview. From the beauty of the land to the poverty in people's lives, from the adoration of their leaders to their acknowledgement of

the political corruption, nurses sought to understand the worldview of Kenyans. As nurses reflected upon this, they became aware of the resentment from some individuals due to the injustice in their lives.

As nurses attempted to make sense of these cultural and contextual factors they compared life in Canada to Kakamega, especially in reference to health care. This led them to question their interventions and contributed to a sense of inadequacy as nurses. They made sense of their feelings of inadequacy through reconciling the contrasts by recognizing times when they were successful in their interventions. When they were unable to do this, they rationalized the gap by giving meaning to their insufficient resources. These coping responses had limited effectiveness, and they found themselves dealing with overwhelming emotions from sadness, to feeling they could not continue, and even anger at the injustice the Kenyans were experiencing. Personal growth became apparent as they became conscious of their own privilege and indeed even the advantages our country affords as compared to Africa.

In Chapter Five a discussion outlines significant results from the study, followed by conclusions. Most important, it provides the implications for practice and the potential for future research in this area. I conclude with a reflective epilogue which summarizes my personal experience on the past three missions to Kakamega, Kenya.

CHAPTER FIVE: DISCUSSION

The central feature of this study is nurses' perspectives during a medical mission. Since caring is the most identifying feature of nursing, it seemed appropriate to use Leininger's transcultural theory as it linked working within a cultural experience to the caring relationship of nursing (Leininger, 1988). The literature review demonstrated the extent of the cultural and contextual aspects impacting nurses' care delivery during the mission. The journals and focus group provided rich data that uncovered how nurses attributed meaning to their experiences and how they made sense of nursing within the culture and context of Kenya.

The primary purpose of this study was to explore the experience of nurses on a medical mission in order to obtain data that were unique to nursing and to the mission experience. Data from the eight journals and subsequent focus group session provided pertinent information for future missions both for CNFA and for other organizations to consider when planning a medical mission. Given that there are few studies of medical missions from nurses' perspectives, limited research on short-term medical missions and some concerns around the ethical stance of these missions, the implications and recommendations from this research provide unique and valuable data for those involved in similar charitable missions.

Discussion and Conclusions

In today's economic and social climate, it seems moral conscience is rising and charitable work, such as missions, are becoming a more common experience for some individuals. Tolchin (2007) describes the "intuitive discomfort" (p. 154) individuals experience as they become aware of the millions of deaths they could prevent by

providing aid to poor nations. Martiniuk et al. (2012) describe how 40% of medical school students and 41% of orthopedic residents have participated in medical mission to low and middle income countries from the United States. Many educational institutes promote this experience as an educational tool enhancing students' attitudes, values, and beliefs (Brown et al., 2012). Campbell et al. (2009) agree that international volunteering is on the rise in America. Although there are no specific Canadian statistics of mission involvement, Statistics Canada (2010) indicates 47% of the population volunteers their time through a group or organization (para. 3). In Ontario, the volunteer rate is 47.7% (Table 1). Although volunteers contributed the largest number of hours for international causes, this was the least likely type of organization for which they would opt to volunteer (Canada Survey of Giving, Volunteering and Participating, 2004, p. 1).

In addition, more retired nurses are interested in volunteering with CNFA. Considering they have the expertise, fewer work and family commitments, and often the finances to participate in a mission, this is an excellent opportunity for recruitment. Statistics Canada (2010) acknowledges those who volunteer the most hours are older, widowed people who are no longer working and do not have children at home (para. 7, 8). While not referring to medical missions in particular, Cocca-Bates and Neal-Boylan (2011) describe how it is a "giving back and gaining back" (p. 100) situation when retired nurses volunteer, with their years of expertise, while enhancing their own quality of life. Indeed, as nurses involved with CNFA for 4 years, we have seen greater interest expressed from various nurses, including those active in nursing as well as retired nurses.

However one wonders if nurses have a realistic notion of what a medical mission actually entails. We are often surprised by nurses' expectations as expressed in their

questions prior to and during the mission. Some implied their expectations were incongruent with their experience so they never returned, and some, did not even volunteer with CNFA again.

However many, including me, encountered the most intense personal and professional growth and awareness we have ever had in our lives, and personally I found myself reflecting on this experience continually in my day-to-day life until I returned again the following year. Although many consider this type of volunteering as selfless, I can truly testify that I believe I gain more from these missions than what I offer. It seems many who participate in voluntary missions benefit far greater than what they simply give in terms of time and money. Brown et al. (2012) distinctly define this as the greatest "transformational life-changing experiences" (p. 895), and I would agree with this statement.

Nevertheless, this mission is a physically and emotionally demanding experience which one cannot take lightly. The individual who is considering this opportunity should seriously reflect upon his/her involvement with thoughtful consideration. On that note, it is our obligation as experienced mission nurses, and CNFA as an organization, to provide nurses with a realistic picture of what the mission entails. Although authors (Brown et al., 2012; Green et al., 2009; Maki et al., 2008; Martiniuk et al., 2012; Suchdev et al., 2007; Timboe & Holt, 2006) reinforce the need for education, training, and support for volunteers on medical missions, they do not address the emotional impact or the psychosocial element of nursing on a mission. In addition, most research on short-term medical missions is not nurse specific but related to nonmedical and medical volunteers. Nursing is a unique profession in that care is a professional responsibility as well as

having a personal dimension (Cortis, 2000). The results of this research must consider implications that are relevant to nurses, respectful to Kenyan people, and achievable in the context of the mission.

Culture

As Canadian nurses journaled on their mission experience and reflected within the focus group, numerous cultural factors were revealed. They noticed the hardship that women and children experience yet the unique bond between the women. They journaled how powerful it was to work with Kenyan nurses and staff yet the struggles they experienced due to cultural differences. Although they found aspects of Kenyan life and people enlightening, they had difficulty making sense of many of the cultural aspects they were confronted with.

Women. Nurses' journals frequently described the cultural aspects of Kenyan women on the mission. They consistently reflected on the gender inequality and hierarchy of men over women at the clinics. They recognized how this placed undue hardship on the women who were already living in destitute conditions.

The Afrocentric emphasis on family, relationships, and children (Collins, 2003; Foster, Phillips, Belgrave, Randolph, & Braithwaite, 1993; Kline, Kline, & Oken, 1992) contributes to the expectations of multiple children and the female as the primary caregiver. Due to high unemployment rates (Kahuthu et al., 2005), the need to migrate for work, the legalization of polygamy, and cultural acceptance of infidelity (Parikh, 2007), women are physically, emotionally, and financially responsibile for the family. Dworkin and Ehrhardt (2007, p. 13) and hooks (2000a, p. 42) describe the "feminization

of poverty" in that more women than men live in poverty, which is very evident in Kakamega.

Both in Africa and Canada, women's economic dependence on men places them at higher risk for HIV infection (Higgins et al., 2010; Williams et al., 2009) due to lack of power in sexual negotiations, stress and victimization in unhealthy relationships, and limited access to health care (Forna et al., 2006; Logan et al., 2002; Sutton et al., 2009). This has huge implications for those of us who are involved with sexual health education when considering culturally appropriate resources for HIV prevention.

Literature supports that in Kenya adolescent women often marry an older man for financial stability for both herself and her family (Parikh, 2007). Extramarital relationships are not to be questioned and "secondary households" (Parikh, 2007, p. 1201) were common in men with wealth who identified themselves as highly Christian. In Sub Saharan Africa wealth and income increases HIV prevalence (Higgins et al., 2010) probably due to the fact that the men can afford numerous wives. Although poverty alone does not cause HIV, it influences stress, victimization, and poor health, which contribute to HIV risk (Logan et al., 2002). The effect of poverty extends beyond sexually transmitted infections and encompasses the hardships women face in the day-to-day responsibility of feeding and taking care of additional children. Indeed even though the injustice for Kenyan women is well documented, it is apparent and well known that the government consistently fails to provide resources for their empowerment (Kahuthu et al., 2005). These facts demonstrate how complex and multifaceted the health issues are that we encounter during the mission.

Sisterhood. Nurses were able to recognize that although Kenyan women experienced tremendous hardship in their lives, the connection between them was powerful. Some feminist authors define the connection between Black women as "sisterhood" (Collins, 1989, p. 762), a unique bond which is distinct to Black women.

This exceptional bond was evident during the sexual health education where groups of women and their children would gather, supporting one another, answering for each other, and laughing together in obvious enjoyment with each other's company. This was not only obvious between women attending the clinic but between the Kenyan nurses working on the mission.

hooks (2000a) describes how Black women's lives are defined by being together, helping one another, and loving one another. Collins (2003) elaborates on how this is a natural connection which does not apply to White women or men. Collins also indicates that Black women's sisterhood is not new, where White women unified to forge their identity. In fact, hooks (2000b) elaborated on how feminist action is an excuse for White women to be together in unity, where for Black women, it is a natural, innate bond. hooks (2000b) continues to describe how she had not ever known a life in which women were not together, helping, protecting, and loving one another.

This is an interesting view which has been discussed in literature. Pearson (2007) interviewed twenty-four "women of Color" (p. 88) and found the women felt they united, not specifically because of race, but due to common interests. Pearson concurred these women were unified by their similar experiences such as disparity.

However, in a case study of eight professional women in college, Vaccaro (2011) found that some women felt there was a lack of sisterhood that was related to

competitiveness between women. This is a similar thought to focus group participants' responses to White women's sisterhood. Other case study participants (Vaccaro, 2011) indicated it was simply different interests and viewpoints that made this bond between the women difficult to achieve. Other women in this research felt they were too busy to spend time on female relationships considering they were employed professionally outside of the home. This result concurred with my focus group participants who felt employment outside of the home made it difficult for women to convene as they prioritized family responsibilities over time with other women.

There was no literature found that examined male bonding experience as compared to the sisterhood identified by hooks (2000a and b) and Collins (1989). Sherrod (as cited in Curry, 1991) suggests men's relationships are based on "doing things together" where as women's are unified by "self-disclosure" (p. 120). Curry (1991) analyzed "locker room talk" (p. 119) of men involved in sports and found competition between the men served to provide the common purpose for their connection with one another. This is an interesting result considering Vaccaro's (2011) study as well as focus group participants' comments which described the competition between women impeded the sense of sisterhood.

Curry's (1991) study also found the men avoided expressions of emotions, caring, or encouragement as this behaviour was seen as nonmasculine. A research project by Way (as cited in Redman, Epstein, Kehily, & Ghaill, 2002) demonstrated that same-sex friendships between men are not as culturally and socially acceptable as female relationships are. Perhaps the lack of male bonding is the result of societal norms of masculinity in which men are socialized to interact with one another in a different manner

than women are. Nevertheless, there is insufficient literature to justify any conclusions regarding Collins' (2003) claims about the exclusivity of Black female sisterhood as compared to White women and men.

It is apparent that focus group participants and some literature identify a difference between White women's connections and Black women's unity in this setting. Whether it was through adversity or circumstances, it was evident there was a strong, supportive connection between the Kenyan women. Perhaps it is more appropriate to call this unique bond a "kinship" (Lugones as cited in Vaccaro, 2011, p. 28) considering the cultural ties and family connections the Kenyan women have with each other.

Whether to be called sisterhood or kinship, the implications of this female bonding are powerful. Indeed Chilisa and Ntseane (2010) indicate how we need to reframe our position on Black women as victims but use the power that African women have in their centrality of motherhood and solidarity in sisterhood.

Dialogue. It became apparent through the findings of this research, that critical discourse was an essential component of utilizing the strength of the sisterhood to work with the Kenyan women. The significance of dialogue was supported by literature.

Many authors describe the importance of dialogue as an emancipatory tool (Freire, 1996; Gosling, 2000; Rule, 2004). Hayes as cited in Taber and Gouthro (2006, p. 60), describe how this "voice" and "naming their experiences" (p. 61) can challenge "power relations" (p. 60) and develop confidence in people (Brookfield, 2005, p. 325). hooks as cited in Brookfield (2005, p. 327) focuses on the collective voice of women together which establishes their common realities and identity, which is essential to empower the Kenyan women in their unity.

Brookfield (2005) and Freire (1996) discuss how dialogue is the key to insightful thinking which initiates a social consciousness and can lead to the "power of the collective" (Brookfield, 2005, p. 47) toward action for liberation. Collins (as cited in Chilisa & Ntseane, 2010) concurs with this indicating that knowledge is socially situated so based on their common experiences and situations, Black women can channel their oppression into critical insights. This gathering of the women together collectively with the power of critical discourse leads to the impetus for social movement.

Homeplace. For communication to be effective, an environment that supports open dialogue is essential. Gouthro (2005) describes the "homeplace" (p. 5) as an ideal site for discourse with the Kenyan women.

Gouthro (2005) states that bell hooks explains how Black women use the homeplace as "a site of resistance . . . shelter against the oppressive forces" (p. 9). Rule (2004) indicates that there must be a designated "dialogic space" (p. 319) for discussion to be liberating and empowering. Gouthro agrees the "homeplace" (p. 5) would be anywhere women feel comfortable to dialogue openly. Chilisa and Ntseane (2010) indicate the dialogical space should not be burdened with White Western influence. Most authors agree that for communication to be effective, it must be uninhibited and free of constraints and coercion (Ewart, 1991; Gosling, 2000; Grace, 2006).

During the mission, the homeplace was often in the field beside the clinic or within a room in the church or school. It was not any place where men could witness them, since it was obvious that the women became uncomfortable with the men around and would not participate if they were present. Brookfield (2005) describes the power in this as "solidarity is realized through the exchange of women's stories of struggle against

patriarchy" (p. 318). As we talked, there were many times when women disclosed stories and events in their lives which were implausible to me, yet evidently shared experiences, as other women joined in verbally and nonverbally in recognition of their mutual circumstances. It was evident, through informal dialogue and a safe space, the women felt liberated to divulge of themselves, and in turn, supported one another.

People. As evident in the results, numerous other cultural factors were identified by nurses as they attempted to make sense of their experiences with the Kenyan people. Although many nurses were aware of the cultural distinctness, some had difficulty accepting certain facets. This led to imposition practices in which there was an expectation of acceptance of Canadian nurses' beliefs and values over and above Kenyan people's traditions.

The initial frustration with the Kenyan time issues was discussed in their journals and the focus group. Gaines et al. (as cited in Torsvik & Hedlund, 2008) describes African orientation is "familism" and "collectivism" (p. 394), the former toward immediate and extended family, the latter toward the welfare of the community. Chilisa and Ntseane (2010) elaborate on this worldview describing Africans as "bound with others" (p. 619) where North Americans define themselves independently as individuals. When exploring literature around Afrocentrism (Collins, 2003; Foster et al., 1993), one can see how the priority of family, community, and collective work and responsibility are traits that are apparent in this culture.

During the focus group, nurses recognized how we prioritized our commitment to "the organization" over "fellow man", unlike the Kenyan's collectivist orientation. Brookfield (2005) describes how individuals "embrace enthusiastically" (p. 93) the

beliefs and practices which support the interest of those in power over us. Like "cogs in the bureaucratic machine" (Fromm as cited in Brookfield, 2005, p. 169), we are accountable to the organizations that employ us by managing our time specifically to schedules enforced upon us. Unfortunately, we are then programmed to comply with these schedules in both our personal and professional lives, and we do not even recognize how we prioritize this over and above any human factors. Through critical reflection, nurses sadly realized the potential for the Kenyan people to begin to comply with Western standards such as scheduling and time management as "Whiteness" permeates their culture.

This is one of the concerns nurses have been aware of over the years. Nurses on this mission and previous years have recognized the North American emphasis on the African culture. Dowden (2009) describes how the greatest impact of European imperialism in Africa was not political or economic but "psychological: the destruction of African self-belief" (p. 62). From the mandatory English enforced in the schools, to the dress of the people, and reverence of White media images from the Kenyan youth, the idolatry of Whiteness seemed to pervade the culture. This cultural suppression was especially accepted by the Kenyans working as professionals, as they were obviously resigned to the fact that it was the only way to be successful.

This applies to North America as well, in which it is documented that Black people's only alternative for accomplishment is to comply with White standards. Roberts (2010) describes how teachers encourage Black students to change their names, speech, and dress when applying for jobs or schools in an attempt to gain an interview or admission. Thus their attempt at success comes at the expense of their culture. This

destruction of the culture and idolatry of Whiteness was concerning to some Canadian nurses, and essential to consider for future missions.

Patients. Among other cultural facets of the mission, nurses' perceptions of clinic patients were described frequently in their reflections. The nurses deliberated the numerous reasons for the "endless requests" of the Kenyan patients. This led to frustration and the feeling of being taken advantage of. This was also reflected upon in the focus group especially with the consideration of the effectiveness of our interventions in terms of empowerment and sustainability.

One of the reasons nurses attributed the endless requests of the patients, was the perception of us as "rich, White women". Although it seemed unbelievable to us to be perceived as wealthy, one cannot be surprised when considering how "privilege is not visible to its holder; it is merely there, a part of the world, a way of life, simply the way things are" (Wildman & Davis as cited in Boyd, 2008, p. 222). Thus, although it seemed shocking to us initially, it is essential for us to internalize the fact that we are privileged people.

As we considered the endless requests, nurses identified how the people are "conditioned" to expect aid. This matter has been discussed at great length during and after each annual mission. It especially became obvious in this mission as we continued to deliberate our "bandaid solutions" months after the mission during the focus group. When considering our work from an ethical standpoint, Tolchin (2007) describes how it is a "humanitarian obligation" (p. 151) for higher income countries to provide aid to those in poorer nations. Indeed some authors identify the provision of charity as a human responsibility.

Ethics of care. One can deliberate on the effectiveness of our interventions, sustainability of our efforts, and we may, indeed, consider if this mission is sensible from an ethical standpoint. Some may believe it is harmful in that it is enabling of Kenyan people's dependence on foreign aid.

Noddings's (2012) ethics of care describes caring as a natural inclination, not a duty or obligation. This is precisely the work of our nurses on the mission. There is no requirement that nurses participate on this endeavor, nor any rewards or incentives. Thus one can assume that the nurses innately care for Kenyan people which is their main purpose of participating in the mission. Nevertheless, Noddings indicates that there is a continuum in which natural caring provides the motivation for ethical caring (Johnston, 2008). This is the point in question for many of our nurses including myself as we dispute whether our actions indeed are evidence of caring. Nelsen (2009) addresses this by considering that "carers *should* be wary of paternalism" (p. 342). In this manner, it is no surprise each group of nurses on the mission every year consistently deliberates the value of our strategies, the concern of "false charity" (Freire, 1996, p. 27), and whether our interventions are truly helpful to those receiving the care. It becomes apparent why nurses experience an internal moral dilemma as they reflect on the effectiveness of our interventions especially considering the difference in health care the patient would receive if in Canada. There really is no solution to this dilemma yet as we deliberate about it frequently we consider sustainable interventions working directly with the Kenyan community workers.

Kenyan nurses. Canadian nurses journaled how they enjoyed working with the Kenyan nurses and recognized the value of this relationship. They appreciated the cultural aspects, how they dressed and talked.

Collins (2003) and Foster et al. (1993) describe how the use of emotions in dialogue is a typical characteristic of Afrocentrism. Nurses' journals described this in the manner they spoke to each other and to the patients. Collins (2003) defines this as the "call-and-response discourse mode" (p. 60) in which meaning is not only conveyed by speech but is punctuated by responses from the listener, which signifies the "consciousness and importance of the hearer" (Tate as cited in Collins, 2003, p. 60). It was evident during morning prayers prior to clinic initiation as well. However, although nurses enjoyed hearing the African dialogue, they felt it was difficult for them to truly get to know the Kenyan nurses personally. Although some had worked together over the previous missions, and attempted communication while working together at the clinics, they still felt aloofness, whether this was cultural, because we are White, or because we are visitors to their country.

Another frustration identified was the work pace of the Kenyan nurses. Being critical care nurses who demonstrated their care through efficient service delivery, they had difficulty making sense of Kenyan nurses' slow pace and lax attitude in response to the overwhelming crowds and ill patients. They thus attributed the Kenyan nurses' response to patients as indifference and lack of caring.

Despite that the concept of caring has prevailed since the days of Florence Nightingale, it is still difficult to encapsulate (Adams & Nelson, 2009; Cortis, 2000).

McCance et al. (2001) acknowledge how the "complex and nebulous nature of caring" (p. 350) makes it difficult to define.

Care. Nursing as a profession has the unique dimension of care and caring from both a personal and professional stance (Cortis, 2000). Indeed Leininger (1988) not only differentiates professional caring from generic caring but compares care as a noun to caring as a verb: "actions directed towards assisting, supporting, or enabling another individual (or group) with evident or anticipated needs to ameliorate or improve a human condition or lifeway" (p. 156). In other words, caring to Canadian nurses was demonstrated by their actions towards the patient.

Leininger (as cited in Cortis, 2000, p. 54) defined professional caring as "those cognitive and culturally learned behaviours, techniques, processes or patterns that enable or help individuals, families or community to improve or maintain a favourable healthy condition or life-way". It seems Leininger's definition of professional caring is a "*learned* [emphasis added] behaviour" (Cortis, 2000, p. 54).

I do not feel that education is primarily the reason for the differences in caring. As well as cultural variances, I believe different individuals attribute varying meanings to caring based on their personal values and life experiences. This is similar to what nurses in the focus group described in the differences between critical care nurses and public health nurses. Although we have the same university based education, we each had different techniques of demonstrating our care. Thus, not only between cultures, but between individuals, the demonstration of caring can be very different. On studying self-concept in nursing, Walter et al. (1999) support this describing the relationship between a nurse's concept of herself and her expressions of caring. Rytterström et al. (2009) agrees

that the "enabling of good care . . . where the nurses were able to act in accordance with their own values" (p. 697). Therefore the differences in nurses' caring may be how she feels, how she feels about herself as a nurse, and her individual beliefs and values.

These factors are not to negate nurses' learned behaviours of caring. It is essential to recognize that the caring nature of nurses should not just be what some may consider an extension of the female caregiving role but requires education, knowledge, and skills (Adams & Nelson, 2009). The difference in professional caring may be due to how nurses are trained. Torsvik and Hedlund (2008) studied nursing students' perceptions of caring. They noted Tanzanian students focused on knowledge of disease process and performance of skills and procedures, where as Norwegian students had more emotional involvement with their patients, spending more time with them. These authors emphasized how Western nursing education emphasizes the caring role of nursing; where as the "curing dimension" (p. 393) is stressed in Tanzania. This was very evident in Kenya in which the nurses were responsible for a large number of patients with various health conditions requiring a wide range of skills where we work in specialty areas with skills specific to the particular health conditions. We recognized how this cure dimension of their training enables them to have a broad skill and knowledge base yet reduces the patient to merely a physical being (Rytterström et al., 2009).

Leininger (1988) discusses that although there can be caring without curing, there "can be no curing without caring" (p. 155). Using a qualitative phenomenological study, Burhans and Alligood (2010) interviewed 12 hospital nurses to explore what quality care meant to them. A consistent theme described how clinical skills are less important than the manner of care delivery, for example by demonstrating respect, advocacy, and

empathy (p. 1694). The nurses from this study cited the meaning of care as ranging from humanism, holism, and competence in performance, patient need fulfillment, therapeutic effectiveness, and leadership, among others.

Most authors agree that although caring is universal, the expressions of caring vary among cultures (Burhans & Alligood, 2010; Cortis, 2000; Leininger, 1988; Rytterström et al., 2009). This was very evident during our mission. Although one of the motives of working with the Kenyan nurses is to role model excellent nursing standards and quality of care, we once again had to recognize the cultural differences in caring, not only from the patients' worldview but also from the staff's professional experience. Also, the concept of our enforcing our nursing standards upon them is a "top down" (Freire, 1996, p. 75) approach in which people attempt to impose their beliefs upon others, integrating (Freire, 1996, p. 55) them into what they consider the superior culture. Mohatany (as cited in Chilisa & Ntseane, 2010) calls this "othering" (p. 618). Authors use this phrase to denote how any information other than Western knowledge is seen as inferior. This is succinctly what we thought, though unintentionally.

This concept has historical roots in imperialism and colonialism when Europe took over Africa in the late 19th century. Porter (1995) describes how nurses from Britain entered Africa in attempts to civilize the people. When African nurses were allowed to practice with British nurses in 1957, they were considered inferior to the White nurses, even if they were senior in experience and education. Freire (1996) describes this as "cultural invasion" (p. 133) in which the invaders impose their own view of the world upon the invaded which curbs their expression, destroying their culture.

Thus it becomes evident that there are differences between expressions of caring between individuals and cultures. The important aspect, however, is that the patient feels cared for. Using face-to-face interviews with 38 patients, Cortis (2000) identified the descriptors of caring into categories including care in the context of a hospital setting. Interestingly enough, respondents felt that many nursing actions were "mechanistic and technical . . . lacking feelings and empathy" (p. 57). When considering what patients perceive as caring, Finn (1994) found how women giving birth described encouragement from nurses during delivery as the most important expression of care to them. Burhans and Alligood (2010) explain that while nurses may believe quality care is focused on good assessments, organized planning, and effectiveness of treatments, patients care more about "communication, listening, kindness and responsiveness of nurses" (p. 1690).

It seems that while nurses are aware of the significance of the psychosocial elements of nursing care, it is often difficult to provide the technical and critical skills patients require while demonstrating empathy and compassion to each and every individual. Adams and Nelson (2009) succinctly describe how nurses' roles must "flow across" the binaries of mind/body and knowledge/virtue dualisms to provide holistic care (p. 13). Florence Nightingale first recognized this in 1852: "nursing is not merely a technique but a process that incorporates the elements of the mind, soul and imagination" (Nightingale as cited in Stockhausen, 2006, p. 55). This balance is what makes nursing a challenging profession.

Kenyan staff. In the focus group nurses identified how powerful it was to work with Kenyan staff on the mission. Despite this, their journals spoke differently as they expressed "frustration" in the cultural traits of the staff. They described disorganization,

lack of communication, inefficiency at clinics, and some mistrust in intent of involvement. This was particularly noted when attempting to plan work such as deworming and strategies within schools which required connecting with various community stakeholders.

We noticed the Kenyan people would endlessly talk, deliberate, and negotiate for extended periods of time. The meaning of this lengthy dialogue to Canadian nurses was to gather information from different points of view, reconcile differences, decide on a resolution, and act on a mutually decided solution. Considering our usual workstyles of schedules and planning, we felt the urgency for preparation and organization of our day for efficient service to our patients. Without clear communication, goals, and planning, it was very difficult to manage our busy clinics with various programs and numerous nurses allocated to run these programs. Literature describes how Africans believe in "the use of dialogue in assessing knowledge claims" (Collins, 2003, p. 59). We discussed how it was difficult for us to make meaning of these lengthy Kenyan conversations as they never seemed to clarify communication or resolve any conflict. However, we recognized that though these long conversations never seemed to meet any of our goals or accomplish any of our desired outcomes, they were one of the unique characteristics of the Kenyan culture.

Nurses also became suspicious of the intent of the work of the Kenyan staff with respect to the mission. This was specifically related to leaders who were appointed significant responsibility in the managing of our clinics. We noted the use of dress and mannerism to demonstrate power and impress others. Dowden (2009) similarly describes

"the Big Man" (p. 77): leaders who also wore suits, jewelry, and had cars with drivers and cell phones to demonstrate their prestige and leadership.

With this, nurses started to question the intentions of these leaders, and if they were entirely altruistic in wanting to help their fellow citizens. Indeed these leaders were impressive to the Kenyan people who looked and listened in awe to their speeches and promises. Freire (1996) describes how charismatic leaders can create false hope in people by depositing lies and reinforcing false myths and promises of good fortune when they are actually interested only in promoting themselves. Perhaps it was an unrealistic expectation to assume Kenyan staff worked with us for entirely altruistic reasons. On the other hand, one might wonder if Canadian nurses may have reasons other than altruism in providing care to the Kenyan people. Indeed I myself have reflected on my own motive behind participating in the mission, acknowledging that it "feels good" to believe I am giving of myself to help another human being.

Canadian nurses "making sense". Teekman (2000) indicates previous experience is the most important factor in guiding nurses to make sense of situations. Many authors agree that skilled nurses use their past experiences (Manias & Street, 2001) and "familiar customs and routines" (Sörlie et al., 2003, p. 288) for patient interactions.

From the reverence of Whiteness, disorganized clinics, treacherous driving conditions, alarming childrearing practices, and disputable "religious" beliefs Canadian nurses reflected on, their difficulty in making sense of these cultural issues became apparent. Most individuals use their own experience to make sense of situations (Bankert & Kozel, 2005; Mezirow, 2000; Taber & Gouthro, 2006); we use the information we

have gathered over a lifetime to draw from. Nurses, in particular, use their nursing experience to guide them for present and future patient encounters.

Stockhausen (2006) describes how expert nurses respond intuitively to patients as they have a repertoire of previous experience. Since most nurses on the mission were experienced by Canadian nursing standards, one can understand how the exceptional situations encountered on the mission would contribute to a sense of unease with their inability to respond intuitively. I can agree there is a sense of apprehension when encountering a patient situation I am not experienced with. I had quite a few encounters in which I was speechless to respond to questions asked by Kenyan patients, and I felt inadequate as a nurse with the inability to provide solutions.

Teekman (2000) describes how in "overload" (p. 1130) situations such as different work environments, new staff, and unique circumstances, "routine thinking" (p. 1128) is no longer effective; thus people respond in a more reactionary manner. This may have contributed to spontaneous reactions of nurses leading to imposition practices (Leininger, 2001c). This was especially so since most of us are women, mothers, and grandmothers so, despite our different circumstances, we could relate to the Kenyan women attending the clinics. I can speak for myself, as I had to suppress my reaction to some of the women's comments during sexual health classes with respect to how they were treated by their husbands and men in the community.

Teekman (2000) also acknowledges that everyone has their own unique preperceptions and responds to experiences based on their "personal baggage" (p. 1132). Most of the nurses on the mission were mothers and/or grandmothers, and are very aware of child safety. Their concerns over the health and safety of Kenyan children were

expressed consistently in the journals and verbally throughout the mission. Since many of the situations we encountered in the clinics involved the health of children, we responded spontaneously to ensure the safety of the child. Though not intending to be disrespectful, nurses may have imposed their childrearing practices and relationship expectations upon Kenyan women by inflicting their values and beliefs upon them.

Critical reflection. Reflection can help those working in health care to make sense of their practice, especially in the "uncertain nature of their workplace" (Driscol & Teh as cited in Burnett & Phillips, 2008, p. e158). The medical mission became this uncertain workplace. Campbell et al. (2009) describe how "immersion" (p. 628) into another culture facilitates reflection of one's own culture and an awareness of one's own power and privilege. I had been hoping that, as the nurses reflected more critically in their journals, they would examine inwardly their own practices and restructure them according to the culture (Larrivee, 2008; Manias & Street, 2001). This may have contributed to a more culturally respectful mission and reduced imposition practices.

Blake (2005) agrees that simply writing about events allows one to recognize the barriers to understanding one's own and others' culture and thus gain insight into one's own practice. Indeed journaling last year guided me through the chaotic milieu of the clinics and helped me to change my sexual health education strategies to become more culturally congruent. Based on this, I had anticipated the practice of journaling to substantially benefit nurses' personal and professional growth during the mission. Brock (2010) identifies critical reflection as one of the steps leading to personal transformation.

However, critical reflection is identified by most authors (English, 2001; Hiemstra, 2001; Larrivee, 2008; Ryan, 2011;Teekman, 2000) as the highest level of

reflection as it challenges one's own beliefs and assumptions (Nielsen, Stragnell, & Jester, 2007). Considering this involves examining and revising assumptions that we have taken for granted (Birbirso, 2012; Keevers & Treleaven, 2011), one can understand how this type of deep reflection can be an uncomfortable experience (Cortis, 2000; Leininger, 2001c) and one which a nurse on a medical mission may not want to engage in since, due to the factors already stated, she may already be stressed and overwhelmed. Although I had hoped journaling would be restorative to guide nurses through this profound emotional impact, I am unsure if it actually was therapeutic for them. During the focus group, only one nurse indicated it helped her in this manner. Undeniably, I had felt it was a healing experience last year, but this year, becoming ill, and possibly due to my awareness of this tool as source of data, it did not seem to contribute to the same cathartic experience as it had in the previous year. Unfortunately, this may be similar to the way other nurses felt about the journaling with respect to participation in the research. In fact, one nurse declined to submit her journal as she stated it brought up too much emotional baggage for her and she was not able to continue.

Nevertheless, critical reflection does not come naturally to most people (Burnett & Phillips, 2008) but has to be learned and developed (Ryan, 2011; Taylor, Mackin, & Oldenburg, 2008). However, some authors feel it may be an innate quality and difficult to teach (Stimson as cited in Ong, 2011). Schön indicates "reflective practice" (as cited in Ong, 2011, p. 145) is an intuitive, spontaneous skill that professionals perform proficiently. Many authors have studied this intuitive response and recognize how it is impossible to actually teach the skills that move a nurse from "novice to expert" (Stockhausen, 2006, p. 55) with the ability to respond instinctively. When assessing

medical students in their final year of education, Burnett and Phillips (2008) found the least consistency in the highest level of reflection which contributed to self-evaluation and behavioural transformation. On the other hand, in a study to explore reflective thinking of qualified nurses, Teekman (2000) found none attained the highest level, "reflective thinking-for-critical inquiry" (p.1131). One may wonder if it is experience alone, or other personal qualities that enable a person to critically reflect. With this fact, one might question if it is possible to teach someone to journal to this highest level of reflection.

During the journal analysis, I noted marked differences in depth of reflection among nurses. It also became apparent in the focus groups as some nurses questioned themselves attempting to make sense of situations encountered, whereas some nurses seemed unable to explore diverse meanings of various circumstances. Teekman (2000) acknowledges how once practitioners can move beyond the "here and now" (p. 1125) to "reflective-thinking-for-action" (p. 1131), they have deeper insights and may be able to realize multiple perceptions and meanings. Deeper reflection of the participants may have led to greater self-awareness, which may have contributed to professional growth and, in turn, helped the patient (Leininger, 1988; Teekman, 2000). However, as indicated earlier, the ability to "reflect for action" (Ong, 2011, p. 145) requires experience to draw from. Considering the mission experience is unique to most nurses, they were not able to apply their Canadian nursing experience to Kenya.

Also, it would have been unethical for me to reinforce journaling to a depth that was uncomfortable for the nurse participants. Many authors recognize the steps to critical reflection start with the "disorientating dilemma" (Brock, 2010, p. 123) described

by Mezirow (2000). Amble (2012) further concurs that this depth of reflection "manifests itself as stress and strain" (p. 268). Thus perhaps it is unavoidable to actually critically reflect for transformation without a sense of unease and discomfort.

I also have to acknowledge that it is unfair for me to assume nurses reflections were not critical simply because they were not written at the depth I aspire to, especially keeping in mind my research agenda. One might ask then, "How do you know when someone is critically reflecting or simply journaling?" Ryan (2011) cites various authors describing the continuum of reflections from reporting to reconstructing (Bain et al. as cited in Ryan, 2011) and "descriptive to dialogic" (Hatton & Smith as cited in Ryan, 2011, p. 101). For example, one journal, and parts of another, simply described an itinerary of our day, similar to a log of events without any personal insights into any of the events that took place.

Many authors have examined how to assess depth of reflections. Lasater and Nielsen (2009) acknowledge that it is challenging to evaluate reflections. Though referring to teacher education, Thorsen and DeVore (2013) illustrate a rubric in which there is a continuum of reflective abilities from being a "concrete thinker" to "alert novice" then "pedagogical thinker" (p. 95). The pedagogical thinker is able to ask why, is guided by a strong belief, has a desire to learn and grow, and is open to feedback and imaginative thinking.

Brookfield (2005), Larrivee (2008), and Nielsen et al. (2007) all agree that in order to be critically reflective one must "question the validity of assumed meanings" (Nielsen et al., 2007, p. 513). Most authors concur that critical reflection "is underpinned by a commitment to social change by reading the world critically and imagining a better

world that is less oppressive" (Leonardo as cited in Ryan, 2011, p. 100). Thus critical reflection consists not only of inward self-questioning, but outward examination of social conditions in which one practices (Larrivee, 2008). Brock (2010) elaborates on this describing how individuals must compare the external world with their internal ideas. She indicates this comparison is the most important step toward transformation, as there is a shifting of perceptions. Mezirow (2000) agrees that there must be a change in viewpoint or a development of a new frame of reference in order for transformation to occur. However, in a study of 256 business undergraduate students, results demonstrated most respondents did not necessarily change their beliefs and assumptions but did still experience transformative learning (Brock, 2010).

It seemed that several nurses were able to examine their experience in light of the culture and context in Kenya in view of their inner assumptions and beliefs, as evidenced by the journals and focus group. However, some seemed to use the journals as a diary or chronological daily report (Lasater & Nielsen, 2009) with very little introspection or self-questioning.

Since the purpose of this study was to explore the experience of nurses on the mission including how cultural and contextual factors influenced their professional practice, I was able to get the perspective of some nurses in this manner. Outside of the research, I had hoped that personal and professional growth through self-awareness would also be achieved through journaling and critical self-reflection. However, it is impossible to truly evaluate self-awareness or assume that critical reflection did not occur for some. It would be valuable to pursue how to support journaling and facilitate critical reflection for future missions.

Context

Team and Kenyan life were the two themes that were identified as contextual factors encountered by nurses during the mission. Although Kenyan life was documented as a positive aspect despite the challenges, team issues became problematic to some individuals.

Team. The initial excitement of commencing the mission together contributed to a sense of "team" which nurses described positively in the journals. However, as clinic days progressed, this bond was fractured and the team climate was altered.

I can also speak about this discomfort in response to the team fragmentation that occurred as I personally felt I may have been responsible for it. Following the mission, as I reviewed the journals and focus group data, I relived this experience as I wrote the narratives. Considering the limited journaling on this sensitive matter, many of these insights stem from my reflections thus may be considered autoethnographical in nature.

Clandinin and Murphy (2009) describe how people's stories are the result of social influence on their lives, their environments, and their personal history. Clandinin (2006) elaborates on the three dimensional nature of a narrative inquiry: "personal and social (interaction) along one dimension, past, present and future (continuity) along a second dimension; place (situation) along a third dimension" (p. 47). Thus in one manner, my story told of this dissension from my interactions with others, considering my past and present experience with the mission, and in the context of the situation that was occurring (Connelly & Clandinin, 2000).

Considering that narrative research is "relational" (Clandinin & Murphy, 2009, p. 599), I wanted to understand what other nurses were feeling and experiencing, especially

those who had not journaled about the fragmentation. However, Coulter and Smith (as cited in Clandinin & Murphy, 2009) admit that even the intent of the researcher to "get into the head of a participant" (p. 601) does not mean they actually know the intimacy of participants' thoughts. Thus although I was concerned about the minimal input from members, and the lack of participation from others, I have to accept the value of the experiences of those who contributed (Clandinin & Huber, 2002). Nevertheless, considering the issue was not resolved during or following the mission, I continued to muse over it especially as I wrote the stories. Indeed Clandinin and Murphy (2009) acknowledge how once the researcher finishes working with the participants "we continue to see ourselves as in relation with them" (p. 600). Consequently, I stewed over my part in this dissension and how it should have been dealt with. Clandinin (2006) admits that there is some tension that may occur once the research leaves the field and composes the texts. This is succinctly what occurred with me.

From the few nurses who journaled about the team dysfunction, and as nurses who experienced previous missions, we had never encountered a fractured team climate before. This change was extremely distressing for many. Based on the past, we had an expectation that the team connection would always be one of the exhilarating mission features. On this mission we experienced a disheartening change. Our perceptions of "team" in comparison to our previous bonding team experiences had been shattered. However, Brown et al. (2012) acknowledge that team unity does not occur "by chance" (p. 897) but with careful planning and preparation. We had simply been fortunate before not to have any of these issues. Although not an enjoyable experience, we can view this

dissension as a challenge to learn how to manage conflict on a personal, professional, and organizational level.

Phillips (2009) defines teamwork as "a group of people working together cooperatively to achieve shared goals" (p. 2). Indeed, Clark (2009) agrees how even a group of diverse people will form a team when they have common goals to which they are directed. Considering the diversity in nurses' experience both professionally and personally, and the range of ages, this was the case for this mission. However, Fry, Lech, and Rubin, (as cited in Clark, 2009) admit that bringing different people together and calling them a team does not mean they will behave as such.

While teams can work effectively even with a diverse group of people and common goals, there are other concepts that define teamwork (Clark, 2009). Clark describes these as goals, norms, roles, horizontal leadership, and communication. Although our nurses' strength was their unified goal of caring for the Kenyan people, other facets were never addressed prior to or during the mission. We had inadvertently made an assumption that these factors would work themselves out as they had always done before. This dissension implies a strong need for team building and educational preparatory sessions prior to the mission.

Kenyan life. The majority of journal entries described in detail the difficulty of Kenyan people's lives, the hardships they experienced, and the many obstacles they faced. Nurses were especially aware of the poor health of the children as evidenced by their malnourishment, presence of ringworm, infected wounds, and lack of adult supervision.

Corruption was everywhere yet difficult to pinpoint due to lack of clear communication from our Kenyan helpers. Kahuthu et al. (2005) acknowledge how Kenyan people are fearful of police so would not seek justice for corruption. It was difficult for nurses to make sense how the people were aware of the corruption yet were mesmerized by the leaders as they campaigned for political power. Freire (1996) describes how leaders use charm to appeal to the people to promote their own self-interest. Some Kenyans spoke openly how leaders they voted for were initially honest men then became corrupt. It seems that leaders have to comply with the direction of those in power or they will be replaced by those who obey (Freire, 1996).

While one nurse in the focus group described a sense of hope on the faces of the people, another felt resentment from patients, particularly young men. While driving to and from clinics, no matter what time of day it was, we noticed how young men gather on street corners in large groups, with an air of restlessness. This is not surprising considering the unemployment and lack of options for constructive social activities or recreation. We discussed how there was the potential for social revolution due to this. This has been one of our concerns each year we return as the rebellion against the "repressive state apparatuses" (Brookfield, 2005, p. 74) such as the law and police, which leads to the likelihood of violence. As these young men begin to recognize their oppression by these authoritative forces, their consciousness will be raised and they may act on this domination to liberate themselves (Brookfield, 2005; Scott, 2006). Porta and Diani as cited in Hall (2006) succinctly describe the four characteristics of social movements exactly as such: "informal interaction networks; . . . shared beliefs and solidarity; . . . collective action focusing on conflict; . . . use of protest" (p. 231). One can

see how the men informally gather on the streets in town, with the common conditions of poverty and unemployment, leading to tension and discord and, in this shared injustice, eventually using protest to fight against their oppressors. In fact, our next mission will be shifted to a later month due to elections and the possibility of violence.

Coping

Nurses reflected on the cultural and contextual factors they were endeavoring to manage during the mission. Although they attempted to handle these issues using various coping strategies, feelings came to the forefront as a significant theme noted consistently throughout nurses' journals.

Bridging the gaps. Nurses' reflections consistently compared and contrasted life in Canada and Kakamega especially with reference to health issues and the care they were providing. They discussed the lack of health resources, necessity of altering their standards of patients' acuity levels, and inadequate interventions they were providing.

With the recognition of the inability to provide quality care according to Canadian standards came an ethical dilemma. Indeed we work by the values of the Canadian Nurses Association, which designates nurses as moral agents to provide safe, compassionate, competent, and ethical care, promote justice through equity, and to be accountable for our actions (Canadian Nurses Association, 2008). In fact, Mendes (2009) discusses how ethical concerns of nurses do not only involve our actions and our patients but we must consider the world as an ethical institution, which means to us, we should provide quality care no matter where we are working. As they recognized it was truly impossible to provide the care they wanted to and were used to, an inner conflict became

apparent, evident by the repetitiveness of the theme and that it was still discussed at length months later in the focus group.

Teekman (2000) describes the three factors contributing to gaps are situational overload, different work environment, and lack of knowledge to process situations. Although there is no specific literature on medical missions, in a study of ICU nurses' stressors and coping methods, Hays, All, Mannahan, Cuaderes, & Wallace (2006) found nurses' most identified perceived stressor was work overload. Although mission nurses did not identify the busy nature of the clinics as "overload," the emotional circumstances they encountered with the tragic nature of the patients' conditions most certainly exceeded their coping resources.

Although I had not identified the mission experience as stressful per se, on reviewing literature, I recognized the nurses were experiencing stress from an emotional, and for some, physical, overload. Indeed stress occurs when "demands that are placed on a person exceed the available resources the individual encompasses to manage" (Lambert, Lambert, & Yamase as cited in Laranjeira, 2011, p. 1756). The mission certainly involved circumstances in which demands exceeded the nurses' resources.

Nurses attempted to cope with the stressors by rationalizing their interventions were the best they could do under the circumstances and/or reconciling the interventions by recognizing rewarding experiences. Hays et al. (2006) validate how this cognitive appraisal bridges the gap between stress and coping. Some authors define this rationalization and reconciliation as "positive reappraisal" (Laranjeira, 2011, p. 1760; Moos & Holahan, 2003, p. 1391), which allows an individual to reframe the circumstance to view it in a positive light.

Feelings. The coping mechanisms the nurses were using during the mission had limited effectiveness and they journaled about being "overwhelmed," "shell-shocked," and questioning if they would be able to continue. On reviewing the literature around nursing and stress, many authors differentiate between styles of coping.

Schreuder et al. (2012) describes the difference between problem-solving coping and emotion-focused coping. The problem-solving strategy intends to solve the problem at hand, thus addressing the source of stress (Schreuder et al., 2012)**.** The emotion-focused coping mechanism regulates the distress the stressful situation causes by using strategies such as positive reappraisal. Most authors concur that problem-focused coping is associated with better mental health (Chang et al., 2007; Laranjeira, 2011), and some even indicate it is better for mental and physical health (Schreuder et al., 2012) than emotion-focused coping is. Indeed, in their study of ICU nurses, Hays et al. (2006) found most of these nurses reported problem-solving as the strategy they used most consistently, and this was consistent with other literature. Nevertheless, it truly was impossible to employ a problem-solving approach when the issues we encountered were so vast and complex, with no possibility of resolving the concerns by a simple strategy.

Although we found the younger nurses seemed to have more difficulty coping, it cannot be assumed age and experience contributes to better coping skills. Hays et al. (2006) found the number of years working in ICU didn't affect nurses' coping methods. However, Maluwa, Andre, Ndebele, and Chilemba (2012) found that nurses with more experience were more resilient to moral distress and able to cope more effectively than their inexperienced colleagues. From my personal experience in nursing, and on these missions, coping and stress management are very individual and difficult to ascertain

until the individual is placed in the actual position. It was evident through the nurses' journals that, despite age and experience, each nurse experienced different practices of coping and stress management while on the mission. In addition, Moos and Holahan (2003) describe how coping is "a dynamic process that fluctuates over time in response to changing demands and appraisal of the situation" (p. 1390); thus one cannot assume how someone will cope based on personality, age, or experience**.**

Implications

The magnitude of the results generated from this study cannot be ignored. The implications of these results will not only contribute to a more effective, supportive, organized, and culturally responsive mission but may facilitate personal and professional growth of mission nurses as they consider their practice in light of the outcomes. Ultimately the implications of the outcomes will benefit the Kenyan people as we consider interventions for empowerment and sustainability.

These implications demonstrate the transcultural theoretical basis of this study with its emphasis on care and culture. The critical foundation also becomes apparent as nurses are challenged in their own norms of practice (Brookfield, 2005) and are compelled to consider empowerment of the clients they serve (Schram, 2003).

Sisterhood

The sisterhood has powerful implications in our work with Kenyan women. The strength in this unification was apparent during sexual health groups when a Kenyan woman would encourage a quieter woman to ask questions, insist the more reserved women take condoms, discipline each other's children so the mother could partake in the condom demonstration, ensure each member obtained resources, and even persuade each

other to participate in the discussion. It was exciting to witness the occasional confident Kenyan woman who would be the first one to take condoms or attempt the condom application. During longer discussions, some of these more assured group members would even admonish another if they were not assertive in addressing their relationship rights.

The first few years I attended the mission and facilitated the sexual health classes, I was apprehensive about having appropriate sexual health information, resources, and supplies. My objective was to convey my knowledge and deliver supplies necessary for the reduction of HIV infection. As my experience with these women has evolved along with knowledge I have gained from this research, I recognize it is not predominantly the delivery of knowledge that matters. As nurses work with women in the groups, it is truly not primarily for the purpose of providing sexual health education but for empowerment and liberation. The implications of the research findings demonstrate the necessity of facilitating critical discourse with the women over and above ensuring we deliver supplies and information that we have deemed as most significant in the past. One of the ways we can do this is through skilled facilitation and ensuring the "homeplace" (Gouthro, 2005, p. 5) setting is ideal for open dialogue.

Brookfield (2005) describes how it is essential to "hold at bay one's own preconceptions, prejudices, and projections" (p. 178) while working with people of another culture. Most authors (Freire, 1996; Ponic et al., 2010) agree that the "top down" (Freire, 1996, p. 75) approach, in which the visitor to the country comes in to inflict his/her values on others, does not work as it does not take into account the worldview of the people toward whom the intervention is directed. Thus it is more essential for nurses

to listen and understand the Kenyan women through their worldview instead of enforcing our ideals upon them (Freire, 1996). The opportunity for this became very evident in the sexual health groups as women opened up, expressed themselves, and acknowledged their real life situations with the encouragement of their peers to support them.

Therefore, dialogue is not just for the sake of talking or delivering information, but rather reflecting together to think critically to transform reality (Freire, 1996). In this manner it is apparent that in addition to encouraging Kenyan women to think critically, at the same time we must also critically reflect upon our own practice of working with the women to facilitate empowerment instead of considering ourselves the expert and knowledge provider. This is consistent with literature that indicates how we need to work with not for people (Freire, 1996) to transform themselves so they can voice their own opinions and make choices in how they live their lives (Boneh & Jaganath, 2011, p. 458).

The critical basis of these implications becomes apparent with its intent to free the oppressed and inspire action (Brookfield, 2005). This, however, is the challenge which I struggle with year after year. I recognize our interventions are fruitless without the actions of the recipients. Freire (1996) agrees that people are empowered by the "praxis" (p. 27) in their pursuit of liberation. I also am aware that my inward quest to empower the people is making an assumption they need to be empowered and that I am the one to do this. Freire (1996) discusses how placing trust in the people you work with is more empowering than providing interventions towards their empowerment. I deliberate what my function is in this over and over in my mind, with no resolution even after three missions.

This approach is essential to consider not only in our interventions with the Kenyan people but in ourselves as we contemplate our own practice. Cornel West as cited in Brookfield (2005) implies, "One sign of commitment . . . is always the degree to which one is willing to be self critical and self questioning" (p. 35) versus overconfident and condescending when educating people. This denotes how imperative it is for nurses on the mission to be aware of our position as we work with groups of women in this manner. Our desire and ability to restructure how we practice indicates a commitment to the Kenyan people.

Emotional Support

As can be construed from the results, feelings became a significant theme that was palpable from the journals and focus group. Thus it is essential to consider nurses' coping and support during the mission. It is also evident, considering the findings and literature around reverse culture shock (Gaw, 2000), that it is necessary to offer support to nurses following the mission.

Another factor to consider is the length of the mission. We have adjusted the time from 1 week to 2 weeks in an effort to reach more Kenyan people. Campbell et al. (2009) states that some mission workers describe emotional exhaustion and have to leave their post early. The fact that this is a short-term medical mission may have some benefits to stress and coping. Campbell et al. (2009) assessed emotional exhaustion of volunteers on short-term medical missions (identified as 14 to 15 days) and found scores improved following the mission and continued to improve at the 6-month follow-up. Also, the study found improvements in the measure of feeling overextended emotionally and the feelings of success and achievement even months after the mission. One may

conclude the experience of helping others may invigorate the helpers as they consider their circumstances in light of others. This indeed is a benefit of a mission which is short term. This is an important factor to take into account as we consider future plans for CNFA, especially with regards to length of missions.

Journaling. Although focus group participants did not entirely concur that journaling was a major factor in helping them cope during the mission, it may be nurturing and healing to some. In addition, Teekman (2000) acknowledges that support from colleagues is essential for individuals to make sense of situations.

Although journaling was used as a data collection tool for this research, at least two of the participants admitted to journaling in their daily lives. Blake (2005) agrees that one of the purposes of journaling is "caring for self" (p. 7), especially for those dealing with overpowering circumstances involving people. Thus, it is worthwhile to encourage journaling for the mission nurses.

One of the implications of this factor is to consider how to facilitate and support nurses to journal, and perhaps even to a greater extent, to critically reflect. Although I had initially contemplated encouraging an open, nonstructured approach, research demonstrated that some structure was necessary even for experienced nurses (Clarke & Graham, 1996; Cox, 2005). Although some authors disagree (Schön as cited in Ong, 2011), some indicate critical reflection "is not intuitive" (Ryan, 2011, p. 101) so must be modeled. Lasater and Nielsen (2009) describe various studies demonstrating how guidance can help students to develop critical reflection skills. However, it may not be applicable to generalize these results to experienced nurses. In fact, though I reviewed the model of reflective journaling identified in Cox (2005) with the nurses prior to the

mission, it did not seem that any had followed this. On the other hand, I did not want to limit their reflections through an entirely scripted approach.

Hayman et al. (2012, p. 27) describe six strategies to encourage reflective journaling, four of which can be applied for the mission: coaching, follow-up contact, promoting comfort, and ensuring safety. A nurse who is an advocate of journaling may be assigned as the journal coach. Perhaps using different questions to encourage critical reflection may be considered to facilitate deeper reflection. Although Amble (2012) and Birbirso (2012) established questions based on situations and dilemmas, it seems more appropriate to avoid the intent to journal as being a negative context.

Keevers and Treleaven (2011) differentiate between reflective and "diffractive questions" (p. 509). Diffractive questions facilitate development of new ways of thinking which considers interrelations. For example "what impact might . . . have on the broader communities with/in which we are entangled?" (Keevers & Treleaven, 2011, p. 509). Brookfield's critical incident questionnaire also identifies some pertinent questions to reflect on "what we do from as many unfamiliar angles as possible" (Brookfield, 1995, p. 28). For example, description of an event that engaged and distanced the writer, if anyone affirmed or confused them, and any situation they encountered that most surprised them (Brookfield, 1995; Phelan, 2012).

In order to promote comfort and safety of nurses on and following the mission (Hayman et al., 2012), supportive dialogue along with the journaling is essential. Alterio (2004) studied a collaborative journaling process in which nine practitioners anonymously contributed to a journal. Though they did not intend to meet together, they desired to do so earlier than expected just because of the positive experience they gained

from contributing to the collaborative journal. In an action research project with service workers, Amble (2012) found respondents improved their ability to handle difficult work situations and dilemmas from participating in a reflection group along with a self-reflective journal. Rogers (as cited in Thorsen & DeVore, 2013) established four criteria for critical reflection, one requiring it be in interaction with others. Indeed one of the recommendations by Brown et al. (2012) is to be diligent about the opportunity for dialogue during a medical mission.

Most authors concur that social support can act as a "buffer" (Matheny et al., 2003, p. 1263) against stressful events. Maluwa et al. (2012) interviewed nurses in Malawi and found they identified venting and peer support as most helpful to deal with morally distressing (p. 197) situations similar to what we encounter on the mission. All authors concur that peer support is crucial to help nurses to deal with stressful events (Lundqvist & Axelsson, 2007; Maluwa et al., 2012; Matheny, Aycock, Curlette, & Junker, 2003). During the focus group, nurses admitted that talking was the most effective strategy for them during and after the mission. Moos and Holahan (2003) described strong family support was associated with better coping, however, mission nurses differed. Focus group participants felt the best support was from each other, especially considering we were the only ones who truly understood what they had gone through. I would concur with this thought as I rarely debrief with families and colleagues, and look forward to reconnecting with the mission group to vent following the mission.

Experienced mission nurses should take the lead to facilitate dialogue as necessary. Brown et al. (2012) describe how team leaders should initiate discussions,

encourage reflections, and identify positive aspects and praise of the day's events. Brown et al. discuss how this does not have to be formally organized, but even on the bus home from the clinics, during meals, or spontaneously throughout the day. This is, in fact, what occurred during our mission frequently. We would often reminisce and debrief in the van following our clinics and during evening meals. This contributes to a proactive approach to avoid possible dissension and disunity within the team.

Hayman et al. (2012) identifies follow-up contact as a significant component to facilitate journaling and critical reflection. Supportive dialogue must be maintained with nurses upon their return to Canada. This is analogous to the expressions of the nurses during the focus group that looked forward to reconnecting following the mission to share their common experiences. This can be accomplished by contacting nurses after the mission, both individually and as a group. Thus both literature and nurses' suggestions infer the relevance of maintaining contact with one another upon return to Canada.

To summarize, the data collection method of journaling that I had hoped would act not only as a cathartic tool during the mission but would facilitate nurses to critically consider how they could reconstruct their practices to become more culturally congruent did not produce the outcome I had anticipated. This not only indicates that greater support for journaling is essential but, based on focus group results and literature it would be more beneficial to provide support for nurses if combined with dialogue. Thus, as experienced mission nurses, we must place more emphasis on the psychosocial elements of the mission such as journaling and communication. These strategies can be implemented when educating nurses prior to the mission and supporting nurses during

and following the mission. These approaches provide a powerful support network for nurses.

Education and Preparation

Although there is limited research on nurse-led medical missions, most authors do agree how education is essential for medical mission volunteers (Brown et al., 2012; Kelley & Salmon, 2007; Maki et al., 2008; Martiniuk et al., 2012; Suchdev et al., 2007). However, on assessing a tool to evaluate STMM, Maki et al. (2008) found the lowest scores in preparedness and education. Although 80% of missions reported having an orientation session, it is unknown what this consists of. The lowest score was in education, with only 60% of missions providing sessions, though they referred to this in regards to educating staff of the mission host country, not necessarily their volunteers. For those that do provide education, it is comprised of teaching participants about the community, the health issues they will encounter, and medical procedures they will provide (Suchdev et al., 2007).

It seems most organizations do not conscientiously provide specific educational and preparatory sessions for their missions. CNFA has improved on their educational preparatory sessions over the years, but the focus has been on the medical components of the mission, with little preparation focused upon the emotional aspect. This research and literature imply that we must be more assiduous in offering structured, resourceful, and interactive sessions involving the psychosocial elements of the mission, not only for those committed to participating but even those considering the mission. This will ensure that those who may be interested become aware of the many facets of the experience prior to making a commitment.

Team building. One of the most significant components to consider for education and preparation for a successful mission is team building. This became very visible from the findings of this study.

Although Suchdev et al. (2007) do identify teamwork as one of the guiding principles for short-term medical groups it is within the scope of ensuring there is a diversely skilled group and supervision of junior team members (p. 319). There are no specific suggestions for establishing a cohesive team or resolving conflict within teams. Brown et al. (2012) describe how medical missions may inevitability lead to team collaboration due to the sense of working together for the common good. This is precisely what occurred in the past. Referring to the ad hoc nature of some missions in which teams have to be mobilized quickly, Timboe and Holt (2006) describe how STMM often have to rely on the volunteers' professionalism to comply with the mission's standards. However, the CNFA mission is planned a year in advance so there is ample opportunity for team building to occur.

Clark (2009) describes norms, roles, horizontal leadership, and communication as essential concepts of teamwork that are necessary for a team to function effectively. Considering the team issues that occurred with this mission, it is essential to address all these aspects clearly. Clark identifies that though goals may bring a team together, norms are also an essential team concept. Norms are "guideposts and expectations for team behavior that identify and maintain the team" (Clark, 2009, p. 222). These are often described as "unwritten rules" (Clark, 2009, p. 222) about communication, manners, decision making, problem solving, and conflict resolution.

Many authors emphasize the significance of communication for effective teamwork. Phillips (2009) indicates that problems with collaboration and communication are the two biggest barriers to effective teamwork. Clark (2009) acknowledges how "without communication teamwork shudders to a halt" (p. 225). Clark describes how "performing" (p. 223) the components of effective teamwork improves positive norms, which strengthens the team. Thus it would be imperative to use practice and repetition (Clark, 2009) through role-play and scenarios. Brown et al. (2012) endorse weekly sessions from the time the mission date is decided upon. Frequently practicing these skills will facilitate the application of conflict resolution strategies and communication skills within the difficult scenarios we may encounter during the mission. Brock (2010) also advocates for role-playing to facilitate critical thinking.

Clear role identification is also a significant component for effective teamwork (Clark, 2009). Clark (2009) defines roles as "clearly defined responsibilities each team member assumes" (p. 223). A few nurses in the postmission evaluation identified this as a problematic issue. They described confusion at the clinics, especially the first few days, until they understood who each individual was and the roles they would assume during the mission. Despite the fact that we had written policy and procedures for clinic roles, which we distributed to each nurse prior to the mission, they did not seem to understand and absorb the tasks of different individuals working in the clinics, including the Kenyan staff. This was probably due to information overload owing to the endless groundwork required for the mission, from the immunizations required, visa applications, and organizing luggage, among other essential preparations required for the travel. The description of specific roles and tasks should not only include Canadian nurses' duties,

but should incorporate the Kenyan staff on the mission. It may also be beneficial to pair each CNFA nurse with a Kenyan nurse, which would promote a relationship with the Kenyan nurses, which was identified by one nurse in the focus group as lacking.

Clark (2009) supports "horizontal leadership" (p. 224) in a team, in which leadership is not exclusive to one person but shared. Parsons (as cited in Clark, 2009) elaborates on this further, describing how there is still one defined leader but all team members participate in a leadership role within their expertise and knowledge. This is in contrast to the hierarchical style in which a leader guides and directs the team with little or no input. Clark (2009) and Brown et al. (2012) indicate this impedes teamwork, as it is not equitable and diminishes the group's ability to function as a team. Horizontal leadership can be practiced in the preparatory sessions through committee involvement (Brown et al., 2012). Brown et al. describe how committees allow for division of labour, leadership, shared responsibilities, and promote positive team interactions. This is a feasible strategy for CNFA considering the numerous committees that are fundamental to raising the funds necessary for medications and supplies for the mission.

The clinic work did involve a horizontal leadership style in which some nurses were assigned as wound care specialists or sexual health nurses, and we rotated medication and triage stations while assigned to deworming and home visits equally. However, I am in agreement with Phillips (2009), who acknowledges that one strong leader is an essential foundation for a team. Nevertheless, I understand the difficulty of this within the clinic environment. One strong leader is pulled in many directions during the mission. I have assumed this role and recognize how difficult it is to perform the leadership duties while ensuring each member is treated equitably. In fact, while

attempting to be fair, our leader allowed other members to change how certain clinic stations worked, and this was unsuccessful. In attempting to correct this, a few members were angered, which may have contributed to the team dissent. However, with emphasis on norms and role identification in the preparatory session, this may decrease the issues we may again encounter with leadership.

Due to the limited literature on medical missions, there are very few recommendations on other team-building strategies in this unique experience. However, DiMeglio et al. (2005) evaluated a team-building approach surveying 350 hospital nurses in a pre-and postintervention study. The intervention involved five activities in three sessions which could be implemented for this mission. One session in particular involved an exercise identifying personal characteristics of people which could be a basis for team differences. Although this research took place in an acute care hospital, results may be applicable to our mission considering many nurses who volunteer work in critical care hospital settings. This strategy has particular relevance considering our discussion in the focus group about "strong personalities" and their impact on a team. Although strong personalities are essential to endure the mission experience, they may contribute to issues impairing team function. In fact Rytterström et al. (2009) studied nurses working on different hospital wards to explore their perception of the care culture. She found that strong personalities "set the tone" (p. 695) for the care, which could contribute to a positive or negative environment.

The Thomas-Kilmann inventory (Sportsman & Hamilton, 2007; Thomas & Kilmann, 1978) may be utilized in this manner to measure a person's behavior in conflict situations. This describes an individual's capability of handling conflict within five

different modes (competing, collaborating, compromising, avoiding, accomodating). Womack (1988) compared five conflict instruments and found the Thomas-Kilmann inventory (TKI) to be reliable, valid, easy to administer and interpret, and flexible to use for efficient training. Compared to the four other instruments, the TKI seems ideal for the context of training for the STMM. As individuals recognize how they employ some modes over others, they may gain self-awareness and consider adapting their styles to more productive conflict management methods pertinent to the team during the mission.

The awareness of various personality types and communication approaches may not only facilitate acceptance of different work styles between Canadian nurses but perhaps may lead to a greater understanding of the Kenyan nurses' approaches to patient care. During the education sessions we must stress the role of the leader, the positions of expert nurses in the clinics, as well as communication skills to deal with conflict management and addressing and resolving dissension. It would also be valuable to role-play the different positions necessary for efficient clinic flow, with emphasis on role flexibility, leadership styles, and negotiation skills.

Recruitment. Another factor to consider for preparing for the mission is finding the right people to participate. As stated earlier, we have an increasing number of interested participants and have had to place some nurses on a waiting list for the next mission. A comprehensive recruitment process has become crucial for future missions.

Nicholson (as cited in Phillips, 2009) implies how an interview process is essential. Most authors agree that while it is difficult to actually gain an accurate picture of personnel qualifications from an interview (Kirkwood & Ralston, 1999), good

interview skills by the interviewer can enhance this process. Macan (2009, p. 203) recommends considering three areas:

1. Establishing a model for interview structure
2. Focusing what constructs should be measured
3. Formulating consistent definitions and measurement of applicant factors

There are differing opinions on using a structured or unstructured interview process. Macan (2009) admits that although highly structured interviews can be valuable predictors, their reliability as compared to the unstructured format is inconclusive. Kirkwood and Ralston (1999) indicate the more structured the interview, the more likely the applicant will provide "scripted responses" (p. 62). Also they may take away from the personal component of learning about the applicant, which is perhaps why most interviewers digress from them (Macan, 2009). Thus it is paramount to have some degree of structure, with flexibility to allow for open exploration of the candidate's personality, which is an essential component to consider for the mission.

Kirkwood and Ralston (1999) discuss "mutual control" in which there is "free flowing conversation" (p. 72) so the interviewer can learn about the applicant while the interviewee can learn about the organization. I believe this is essential for the interviews for the mission so that, while we are assessing the applicant's qualifications, he/she is also becoming more aware of what the mission entails. Although related to new nursing graduates, Fey (2000) recommends asking open-ended questions such as "On a mission it is typical to encounter . . . tell me how you would deal with a similar situation." This places the candidate at ease and initiates open dialogue.

When considering what constructs to measure during the interview, it is not only important to evaluate for nurses' technical skills but most significant to measure behaviour and personality. Considering qualities for travel nurses, Jackson (2003) advises flexibility, assertiveness, desire for challenge, and interpersonal skills as desirable qualities. Costa and McCrae (as cited in Macan, 2009, p. 208) are known for the "Big Five" personality dimensions such as openness, conscientiousness, extraversion, agreeableness, and neuroticism. Based on the results of this study, it is essential to assess factors such as the ability to work in a team, resiliency, stress management, and cross-cultural awareness. In particular, attitude, the ability to deal with conflict, and working within a team are components to be evaluated for our interview. Phillips (2009) indicates that attitude is usually the root of conflict and thus has a large influence on team function. Macan (2009) advises using more than one item per construct for accurate measurement. Thus it will be essential to establish a set of questions for each construct and criteria how to measure them.

I initially thought the interview questions should not be leading to identify what traits we are looking for in nurses considering the mission. I had assumed these characteristics would stand out naturally and come forth in the interview. However Klehe, König, Richter, Kleinmann, and Melchers (2008) and Macan (2009) emphasize transparency in the interview process. Transparency is "the degree to which interviewees are informed about the particular requirements posed by the interview's questions" (Klehe et al., 2008, p. 108). Examining two studies on transparency in structured interviews, Klehe et al. found greater construct validity with the transparent interview. However, there was no significant difference in criterion-related validity under

transparent versus nontransparent interviews. Nevertheless, for our recruitment, it seems appropriate to establish a semistructured transparent interview, especially considering the psychosocial components of the mission. This type of interview is also ideal to assess how a candidate's personality would fit within the team and how they would work within the culture and context of the experiences they may encounter during the mission.

Clark (2009) identifies communication as a distinct concept of an effective team. Therefore, addressing all of the factors above in the recruitment and interview process and interactive educational and preparatory sessions may enhance communication skills in order to develop a cohesive team. A supportive team is essential for this mission experience. In fact, we did not become aware of how significant this was until this past mission when team dissension occurred.

Cross-cultural training. Findings from this research demonstrate how, despite their awareness of cultural diversity, many nurses had difficulty accepting the different beliefs of Kenyan people, patients, nurses, and staff. Cross-cultural education is a significant requirement for the educational preparatory sessions prior to the mission. Even with limited literature on short-term medical missions, most authors do agree that there is a need for "cross-cultural" training in the predeparture sessions (Martiniuk et al., 2012, p. 7).

Eiser and Ellis (2007) identify how knowledge of the culture and modification of attitudes are necessary components for cross-cultural training. With specific reference to the African American patient that can be utilized to prepare for the mission in Kenya, Eiser and Ellis describe the key components of the training as including education about

the historical influence on health, religious impact on health care, use of home remedies, and distrust of health professionals.

As described earlier and evident on our mission, religion is the source of support for most African people even with different beliefs and denominations (Eiser & Ellis, 2007; Hatcher et al., 2008; hooks 2000a; Morgan, 1996; Thompkins, 2004). Religion and history also play a role in health care in Kenya with respect to folk beliefs and remedies. However, it is important for us, as visitors to the country, to recognize the meaning of illness within the context of culture for each patient (Betancourt as cited in Eiser & Ellis, 2007).

Eiser and Ellis (2007) suggest an experiential element to the training to facilitate trust, respect, and culturally cognizant interactions. Role-play and case scenarios will allow us to include cultural components of the mission work within the real-life situations we encounter. Although mistrust in us as White educated women and nurses has never been an issue on the mission, demonstrating respect of their traditions will hopefully alleviate any distrust they have in us as visitors to their country.

Describing a framework for cross-cultural medical education, Betancourt (as cited in Eiser & Ellis, 2007) implies that self-reflection can facilitate an awareness of attitudes. This is parallel to our emphasis on journaling, to encourage nurses to critically reflect on their practice as they work with Kenyan people. For example, through journaling I became aware of my expectation of the Kenyan women to be less subservient to their male partners, and more assertive in their relationship rights. I had to recognize my White Western attitude was not harmonious with the African emphasis on motherhood, childbearing, and family. Thus cross-cultural training with education and interactive

sessions will not only educate nurses about the Kenyan culture but will facilitate them to self-reflect on their own practices to become more culturally respectful.

In addition, it is apparent from the findings that the signs of culture shock (Brown & Holloway, 2008; Stewart & Leggat, 1998) and reverse culture shock (Gaw, 2000) should be an essential component of this cross-cultural training. Adler (1975) describes how many view culture shock as a negative consequence yet it can be an opportunity for learning, self-development, and personal growth (p. 14). Nurses must be made aware of the potential emotional responses to working with another culture during and following the mission. Although the education sessions are designed to inform and prepare new nurses for the mission, experienced nurses must also be aware of the signs and symptoms of culture shock and how to support their colleagues through this.

Implications for theory. While recognizing the significance of cross-cultural education, one must emphasize the theoretical foundation of this training. The transcultural theoretical perspective was apparent throughout this study with the evidence of care and culture within the findings. Cross-cultural training, in particular, has considerable implications for exercising critical theory.

Although this research utilized critical theory from the context and culture of Kenya, as nurses we must recognize how we also are oppressed by the conventions under which we are expected to practice. Without question, most nurses assume and internalize these norms which perpetuate the status quo (Brookfield, 2005). This became very apparent through nurses' journals as they questioned cultural practices and compared them to the norms of health care in Canada. These norms represent White middle-class values which are not compatible with cultural practices we encounter in Kenya. It is

essential that we become aware of our unconditional acceptance of these White middle-class standards and challenge the ideologies which we have blindly worked under. It is only then that we will be able to restructure our practice to become more culturally congruent.

Cross-cultural education must underscore the ability to be self-critical and facilitate nurses to become aware of their assumptions, question their norms, consider alternative practices, and revise their nursing interventions accordingly. Indeed Brookfield (2005) acknowledges the significance of theory to change practice and inspire action.

Looking Ahead

Expanding the use of theory has implications for future research and practice. Although Leininger's transcultural care theory was used to explore care and culture from the Canadian nurses' perspectives, the ethnonursing method was not utilized to the full capacity due to the limitations of this research. The ethnonursing method using the sunrise model with a critical theory perspective would impart valuable data for future missions, empower nurses to gain professional insight, and enhance the care provided to the Kenyan people.

Future theory. Douglas et al. (2010), Leininger (2001a), and Morgan (1996) acknowledge that to truly utilize transcultural care theory one should employ the ethnonursing method which examines the emic or insider's viewpoint. In this case the key informants would be the Kenyan people as well as the Kenyan nurses. Considering the context and culture of the mission, and ethical constraints with traditional research, it would have been difficult to use the Kenyan people as the sample population.

However, it may be feasible to modify the ethnonursing method to examine how nurses as a culture work within the culture of Kenya. Since nurses themselves may be deemed a cultural group with their learned skills, shared beliefs, and common norms, one may be able to consider their perspective as "emic" data from "insider" perspectives (Douglas et al., 2010, p. 378S, Leininger, 1988, p. 153) which is consistent with the ethnonursing method. Despite the commonality between nurses, it was evident from the findings that Canadian nurses were not entirely uniform in their demonstration and provision of care. In addition, nurses are taken out of their norms and routines while working on an international mission. Thus it would be valuable to further explore how nurses as a culture provide care to people of another culture using the sunrise model (Leininger, 1988; Leininger, 2001a) and a critical theory perspective.

Similar to critical theory, the sunrise model identifies how social structures as well as cultural dimensions impact on factors that influence health. This model interprets findings to guide nursing actions along three modalities. Cultural care preservation implies that behaviours that are good for health should not be changed where cultural care accommodation and repatterning involve negotiation with the client to restructure their activities in a manner that is respectful to their culture while improving their health (Leininger, 1988; Morgan, 1996). It would be desirable that, with the critical focus underlying the cross-cultural training and the use of this model, nurses would be able to identify the social and political conditions that not only impact on their clients' health behaviours but influence their own assumptions of what is healthy and what is not. This may enable nurses to be more tolerant of the differences between themselves, and also between Canadian and Kenyan healthcare provision. In turn, they may gain awareness to

revise their nursing practice accordingly that enables the cultural care restructuring modality, which is consistent with the sunrise model.

Future research. It was apparent from the findings, how care as a concept had vast implications for Canadian nurses working in Kenya. Although care as a phenomenon is difficult to define, it has significant implications for further research for future missions. It would have been ideal to uncover Kenyan people's perceptions of what caring means to them and how care is demonstrated to them. This may have imparted significant data on how Kenyan people perceive care and illustrate Kenyan nurses' views of caring for people of their own culture.

Unfortunately, there are many challenges in undertaking this type of research. First and foremost is the fact that there would be a "power-over" (Ponic et al., 2010, p. 330) inclination in that we are providing treatments for patients and a stipend to Kenyan nurses working on the mission. There is thus the potential for people to respond in ways they believe acceptable to the researcher (Creswell, 2008; Schram, 2003). This is especially relevant considering the people's numerous requests from us. Indeed just the fact that we are White visitors to the country may contribute to participants substituting honest responses for those deemed more acceptable to our culture. Depending on the data collection methods, it would be very difficult to obtain verbal or written replies to the research question(s) without a translator considering the language barrier. Informed consent would be impossible to attain before the mission to apply for ethics approval and difficult to obtain due to language barriers. Thus, although revealing valuable data for future missions, there are many ethical dilemmas and constraints with this type of research.

Considering this, alternative research methods may be more appropriate. Chilisa and Ntseane (2010) established some recommendations for research with indigenous people. They describe how the researcher must be "transformative healer, working with the community and actively involved in healing, building communities and promoting harmony" (p. 619). Similarly, Douglas et al. (2010, p. 383S) describes how grounded theory can be used to study interactions that illuminate the meanings of relationships, holism, health, and healing in a transcultural context. An ethnographic design with the researcher acting as a participant observer enables the type of research which Chilisa & Ntseane (2010) define as "action-oriented and values-oriented" (p. 620). With this the researcher not only observes the subjects but participates with them in their daily lives and activities (Douglas et al., 2010). Indeed with this method, the researcher could observe Kenyan patients and nurses' responses to care as well explore the differences between Canadian nurses' care patterns. Chilisa and Ntseane discuss how these alternative research methods demonstrate respect for the participants' standpoint and create an interdependence between worldviews and knowledge systems. The theory generated from this design and method (Mitchell & Cody, 1992) would increase the understanding and meaning of cultural diversity in the world of nursing (Douglas et al., 2010) which is significant to this mission.

Although I had originally identified the purpose of future research to explore care from Kenyan people's perspectives, the grounded theory method allows the theory to emerge from the data (Thomas, 2006). Thus those leading the study must keep in mind the research is for discovery and emergence of theory, without any predetermined

assumptions or justification of preconceived notions from the researcher (Mitchell & Cody, 1992).

A significant component from Chilitsa and Ntseane's (2010) recommendations is to facilitate expression of the participants in their own metaphorical language. During the mission we led a quilt project with the school children by asking them to draw their life and hopes in Kenya on a quilt square which was assembled into a quilt following the mission. Similarly, one can use art or cultural artifacts to provide insight into the peoples' practices and beliefs. After one sexual health class, the children sang and clapped a traditional folk-song as a gesture of gratitude to me for working with them in the school. I enjoyed this so much that we began this tradition with the Kenyan nurses and they sang and clapped "Kalabanga" with Canadian nurses at the end of the day. Thus music and dance may be part of the nonconventional methods used to explore meaning from the Kenyan people's perspectives.

Summary of Implications

The results of this research have inferred some significant implications for practice and theory. It became evident that emotional support is necessary for the nurses on the mission, and though journaling may facilitate this, peer support is most essential to augment this. A supportive team will sustain nurses as they encounter the most intense emotions and experiences they have ever met in their nursing careers. Most important is the necessity for offering comprehensive educational and preparatory sessions for all participants considering and committed to the mission. Through this training, nurses may be able to consider their interventions when working with Kenyan people and align their nursing care to be more culturally cognizant. It would be ideal to pursue further research

utilizing transcultural and critical theory to a greater depth and consider alternative research methods to explore care from the Kenyan people themselves.

Recommendations

This research and the implications demonstrate valuable recommendations to consider for future missions. It is essential that we provide mandatory preparatory sessions for nurses interested in and committed to participating in the mission experience. This would involve an interview process for all interested applicants and attendance at all educational sessions. The educational sessions must include team-building strategies focusing on personality styles, roles of team members, communication skills, and conflict management. Cross-cultural training would be a mandatory component of these sessions, and would emphasize the necessity of critical reflection upon one's own practice. A psychosocial element should consist of possible emotional responses to experiences encountered during the clinics and coping mechanisms and support for these reactions. Techniques of journaling and dialogue may be emphasized here.

These educational preparatory sessions should be interactive, using role-play and actual case studies in which participants can learn about cultural situations they may encounter and how they may consider their responses and practices to be more culturally congruent. Individual nurses may be assigned to roles such as journal coach, facilitator of debriefing, supportive counselor, and/or responsible for postmission follow-up activities. Simply attending and participating in these preparatory sessions may assist nurses to develop a bond with each other which may contribute to team cohesiveness even prior to departure.

Most significant from the findings of this research, is the necessity of emotional support for nurses during and after the mission. Journaling may be valuable for the cathartic effects but ongoing dialogue is vital to support nurses during and after the mission. It is essential that CNFA, as an organization, and nurses on the mission recognize the need to support one another for this challenging experience.

From my years of experience working on the mission and with the findings from this research, I recognize the overwhelming needs the Kenyan people have. It would be desirable to undertake further research exploring the mission experience from the perspective of the Kenyan people themselves, especially considering what care means to them. Inquiring what the Kenyan nurses' views of caring would provide valuable results which may facilitate Canadian nurses to become aware of the diversity and respectful of the differences. Thus they may be able to alter their behaviour and practices to become more culturally congruent. An ethnographic design with grounded theory methods will facilitate emergence of theory to better understand and assimilate with the Kenyan people. In fact, this study and further research may serve to empower the people so culturally relevant and sustainable interventions can transpire. It is only with committed individuals and a cohesive team that we can work with Kenyan people to guide them to recognize their abilities to change their world.

Epilogue

Some people believe in fate, some people believe in God's plan, and some don't think beyond the moment. I have wanted to go to Africa since my first year of university, but life circumstances delayed my going. Working in the field of nursing led me to the Canadian Nurses for Africa, a grassroots group of nurses. Finding this group brought me

to the place of my heart's desire that I had been yearning for for the past 20 years. I had no idea if the yearning and desire I felt so long ago would still be present when I arrived in Kenya, but it was there, stronger than ever, and it has grown stronger with each passing mission. It is to the point that I don't want to leave when I am there. I have no idea why I love Kenya, the people, the sites, the smells, and sounds, but I do, and it's deep inside my core, beyond any description I could describe here on paper.

Two factors have made my experience exceptional. I ordered Paulo Freire's (1996) *Pedagogy of the Oppressed* a month before my departure, thinking it would be a good book to read on the long journey to my destination. My order from Amazon kept getting delayed until it arrived in my mailbox the day before my departure. Fate, God's plan, fluke, I don't know, but reading this book provided greater depth to this amazing experience.

Second, I had been encouraged to journal while I was away. I did not do this during my first mission due to the business of the clinics, exhaustion, and lack of time. Thanks to my Advisor's advice, as part of an assignment I journaled the following year. Despite the same issues, I found I could not journal enough. I could hardly wait to write my reflections and even brought a booklet with me to clinic during clinics and travel to jot down thoughts and reflections I was experiencing so I would not forget one moment. Journaling provided me with an even greater depth of reflection than I had experienced before.

These two factors led me to choose the topic for my research. The emotional experience of the mission is all encompassing. It is unexplainable. It is ingrained so deeply in me that I believe I will be involved in this mission work for the rest of my life,

and hopefully in a broader extent. I sincerely hope that this study not only will provide a depth of personal awareness and potential growth to all nurses involved in past and future missions but will benefit the Kenyan people who this mission and this study are all about. I am thankful that I met the CNFA nurses and followed my yearning to travel to Africa. I am grateful to the Kenyan people who allow me to care for them. With all I endure, they are in my heart forever.

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Appendix

Focus Group Interview Questions

1. What are your thoughts around this "sisterhood"? Do you think Canadian women experience this same "sisterhood"?
2. Do you think younger Kenyan women experience the same inequity between males and females that the older women describe?
3. Do you think these traits (focus on family and community) have anything to do with the "Kenyan time" issues we ran into?
4. What meaning do you attach to the fact that patients and nurses continually ask Canadian nurses for "stuff"? Are we creating a welfare society?
5. What are your feelings about Kenyan nurses' and staff assistance on the mission?
6. Did the concept of team affect your practice during the mission?
7. Is there anything that helped you, would help you, or didn't help you with these overwhelming feelings during the mission?
8. Is there anything else that you thought was important that you would like to add, that I didn't address?

Later question for clarification:

What does "strong personality" mean to you?